DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 430, 431, 433, 435, 440, 447, and 457

Office of the Secretary

45 CFR Part 155

[CMS-2334-P]

RIN 0938-AR04

Medicaid, Children's Health Insurance Programs, and Exchanges: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Exchange Eligibility Appeals and Other Provisions Related to Eligibility and Enrollment for Exchanges, Medicaid and CHIP, and Medicaid Premiums and Cost Sharing.

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Proposed rule.

SUMMARY: This proposed rule would implement provisions of the Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the Affordable Care Act), and the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). This proposed rule reflects new statutory eligibility provisions; proposes changes to provide states more flexibility to coordinate Medicaid and the Children's Health Insurance Program (CHIP) eligibility notices, appeals, and other related administrative procedures with similar procedures used by other health coverage programs authorized under the Affordable Care Act; modernizes and streamlines existing rules, eliminates obsolete rules, and updates provisions to reflect Medicaid eligibility pathways; revises the rules relating to the substitution of coverage to improve the coordination of CHIP coverage

with other coverage; implements other CHIPRA eligibility-related provisions, including eligibility for newborns whose mothers were eligible for and receiving Medicaid or CHIP coverage at the time of birth; amends certain provisions included in the "State Flexibility for Medicaid Benefit Packages" final rule published on April 30, 2010; and implements specific provisions including eligibility appeals, notices, and verification of eligibility for qualifying coverage in an eligible employer-sponsored plan for Affordable Insurance Exchanges. This rule also proposes to update and simplify the complex Medicaid premiums and cost sharing requirements, to promote the most effective use of services, and to assist states in identifying cost sharing flexibilities.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on **February 13, 2013**.

ADDRESSES: In commenting, please refer to file code CMS-2334-P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (please choose only one of the ways listed):

1. Electronically. You may submit electronic comments on this regulation to **http://www.regulations.gov**. Follow the "Submit a comment" instructions.

2. By regular mail. You may mail written comments to the following address ONLY:

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

Attention: CMS-2334-P,

P.O. Box 8016,

Baltimore, MD 21244-8016.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. By express or overnight mail. You may send written comments to the following address ONLY:

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

Attention: CMS-2334-P,

Mail Stop C4-26-05,

7500 Security Boulevard,

Baltimore, MD 21244-1850.

4. By hand or courier. Alternatively, you may deliver (by hand or courier) your written comments ONLY to the following addresses prior to the close of the comment period:

a. For delivery in Washington, DC--

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

Room 445-G, Hubert H. Humphrey Building,

200 Independence Avenue, SW.,

Washington, DC 20201

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without federal government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. For delivery in Baltimore, MD--

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

7500 Security Boulevard,

Baltimore, MD 21244-1850.

If you intend to deliver your comments to the Baltimore address, call telephone number (410) 786-7195 in advance to schedule your arrival with one of our staff members.

Comments erroneously mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

For information on viewing public comments, see the beginning of the "SUPPLEMENTARY INFORMATION" section.

FOR FURTHER INFORMATION CONTACT:

Sarah deLone, (410) 786-0615, or Stephanie Kaminsky, (410) 786-4653, for provisions related to revisions to eligibility notice and fair hearing appeal processes and additional eligibility changes for Medicaid and CHIP.

Melissa Harris, (410)786-3397, for provisions related to essential health benefits.

Leigha Basini, (301) 492-4307, for provisions related to Affordable Insurance Exchanges.

SUPPLEMENTARY INFORMATION:

Executive Summary

This proposed rule would implement provisions of the Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the Affordable Care Act), and the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). This rule reflects new statutory eligibility provisions, proposes changes to provide states more flexibility to coordinate Medicaid and CHIP eligibility

notices, appeals, and other related administrative procedures with similar procedures used by other health coverage programs authorized under the Affordable Care Act. This proposed rule also modernizes and streamlines existing rules, eliminates obsolete rules, and updates provisions to reflect new or revised Medicaid eligibility pathways. This rule also implements CHIPRA eligibility-related provisions, including eligibility for newborns whose mothers were eligible for and receiving Medicaid or CHIP coverage at the time of birth.

This proposed rule amends the final rule published on April 30, 2010, titled "State Flexibility for Medicaid Benefit Packages," which implemented the provisions of section 1937 of the Social Security Act (the Act), and established a state option to provide Medicaid benefits using benchmark or benchmark-equivalent coverage. In an effort to bring consistency and clarity to part 440, we are removing the terms "benchmark and benchmark-equivalent plan" where they appear together and are replacing these terms with "Alternative Benefit Plan."

Beginning in 2014, individuals and small businesses will be able to purchase private health insurance through competitive marketplaces called Affordable Insurance Exchanges, or "Exchanges." This proposed rule would: (1) set forth standards for adjudicating appeals of individual eligibility determinations and exemptions from the individual responsibility requirements, as well as determinations of employer-sponsored coverage, and determinations of SHOP employer and employee eligibility for purposes of implementing section 1411(f) of the Affordable Care Act, (2) set forth standards for adjudicating appeals of employer and employee eligibility to participate in the SHOP, (3) outline criteria related to the verification of enrollment in and eligibility for minimum essential coverage through an eligible employer-sponsored plan, and (4) further specify or amend standards related to other eligibility and enrollment provisions. The intent of this rule is to afford states substantial discretion in the design and operation of an Exchange, with greater standardization provided where directed by the statute or where there are compelling practical, efficiency or consumer protection reasons.

This rule also proposes to update and simplify the complex Medicaid premiums and cost sharing requirements to promote the most effective use of services and to assist states in identifying cost sharing flexibilities. To that end, we propose to update the maximum allowable cost sharing levels, in particular expanding upon the flexibilities related to drugs and emergency department (ED) usage. We propose new options for states to establish higher cost sharing for non-preferred drugs, and to impose higher cost sharing for non-emergency use of the ED.

Besides the specific updates to nominal amounts, we propose to greatly simplify and streamline the entire premiums and cost sharing regulation "in a manner that is consistent with simplicity of administration and the best interests of the recipients," in accordance with section 1902(a)(19) of the Act. This proposed rule would no longer distinguish between the two statutory authorities for premiums and cost sharing (sections 1916 and 1916A of the Act) and instead would simply lay out the parameters under which premiums and cost sharing are permitted.

Finally, this rulemaking provides notice that we are considering, for purposes of the initial open enrollment period for enrollment in a Qualified Health Plan through the Exchange, whether various provisions of the Medicaid and CHIP regulations should be effective October 1, 2013, or whether a later effective date is appropriate.

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Acronyms

Because of the many organizations and terms to which we refer by acronym in this proposed rule, we are listing these acronyms and their corresponding terms in alphabetical order below:

[the] Act Social Security Act

Affordable Care Act - The Affordable Care Act of 2010 (which is the collective term for the Patient Protection and Affordable Care Act (Pub. L. 111-148) and the Health Care and Education Reconciliation Act (Pub. L. 111-152))

AFDC Aid to Families with Dependent Children

BBA Balanced Budget Act of 1997

BHP Basic Health Program

CHIP Children's Health Insurance Program

CHIPRA Children's Health Insurance Program Reauthorization Act of 2009

CMS Centers for Medicare & Medicaid Services

[the] Code Internal Revenue Code of 1986

DHS Department of Homeland Security

DOL U.S. Department of Labor

DRA Deficit Reduction Act of 2005

EITC	Earned Income Tax Credit
EPSDT	Early and periodic screening, diagnosis, and treatment
FEHBP	Federal Employees Health Benefits Program (5 U.S.C 8901, et seq.)
FFE	Federally-facilitated Exchange
FFP	Federal financial participation
FMAP	Federal medical assistance percentage
FPL	Federal poverty level
HCERA	Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152, enacted March 30, 2010)
HHS	[U.S. Department of] Health and Human Services
IHS	Indian Health Service
INA	Immigration and Nationality Act
IRA	Individual Retirement Account
IRC	Internal Revenue Code of 1986
IRS	Internal Revenue Service
MAGI	Modified adjusted gross income
OMB	Office of Management and Budget
OPM	U.S. Office of Personnel Management
PHS Act	Public Health Service Act
PRA	Paperwork Reduction Act of 1985
PRWORA	Personal Responsibility and Work Opportunity Reconciliation Act of 1996
QHP	Qualified Health Plan
SHOP	Small Business Health Options Program
SMD	State Medicaid Director
SNAP	Supplemental Nutrition Assistance Program

SPA	State Plan Amendment
SSA	Social Security Administration
SSI	Supplemental Security Income
SSN	Social Security number
TANF	Temporary Assistance for Needy Families

I. Medicaid Eligibility Expansion Part II

A. Background

1. Introduction

The Patient Protection and Affordable Care Act (Pub. L. 111–148, enacted on March 23, 2010), was amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152, enacted on March 30, 2010). These laws are collectively referred to as the Affordable Care Act. In addition, section 205 of the Medicare & Medicaid Extenders Act of 2010 (Pub. L. 111–309, enacted December 15, 2010) (MMEA) and the Middle Class Tax Relief and Job Creation Act of 2012 (Pub. L. No. 112-96, enacted February 22, 2012) made additional amendments to the Social Security Act (the Act) provisions affected by the Affordable Care Act.

The Affordable Care Act extends and simplifies Medicaid eligibility and on March 23, 2012, we issued a final rule (referred to as the "Medicaid eligibility final rule") addressing certain key Medicaid eligibility issues.

This proposed rule provides states with additional flexibility in beneficiary appeals, notices and related procedures, updates CMS regulations to fully reflect changes in Medicaid eligibility created under the Affordable Care Act and existing legislations, and modernizes administrative procedures to further promote coordination across multiple health coverage programs, including purchase of coverage through the Exchange with advance payments of the premium tax credits and cost sharing reductions, as authorized by the Affordable Care Act,

Medicaid and the Children's Health Insurance Program (CHIP). These coverage programs are collectively referred to as "insurance affordability programs."

2. Legislative Overview

This proposed rule reflects and implements Medicaid and CHIP eligibility and enrollment provisions of the Affordable Care Act including:

- Sections 1411 and 1413, which ensure coordination in the eligibility, verification, and enrollment systems for Medicaid, CHIP, Basic Health Programs, and Exchanges. This includes ensuring verification of individuals' citizenship status.
- Section 2001, which provides for expanded Medicaid eligibility for adults under age 65.
- Section 2002, which sets out new financial eligibility methodologies for Medicaid for certain populations.
- Sections 2004 and 10201, which expand Medicaid coverage for individuals under age 26 who were receiving Medicaid when they aged out of foster care.
- Section 2101, which sets new financial eligibility methodologies for CHIP.
- Sections 2201 and 1413, which simplify and coordinate eligibility and enrollment systems across insurance affordability programs.
- Section 2202, which permits hospitals to make presumptive eligibility determinations for all Medicaid eligible populations.
- Section 2303, which provides a state option for Medicaid coverage limited to family planning or family planning related services under the state plan.

This proposed rule also makes changes to the Children's Health Insurance Program (CHIP) that reflect and implement certain provisions of the Social Security Act, Affordable Care Act and the Children's Health Insurance Program Reauthorization Act of 2009 (Pub. L 111-3, enacted on February 4, 2009) (CHIPRA) including:

- Sections 111, 113, and 211 of CHIPRA, which require automatic eligibility for newborns whose mothers were receiving medical assistance at the time of birth.

- Section 2105(c)(10) of the Social Security Act, as well as sections 1906 and 1906A of the Social Security Act, which apply a cost-effectiveness test to premium assistance set forth at Section 10203(b) of the Affordable Care Act.

3. Overview of the Proposed Rule

The proposed amendments to 42 CFR parts 430, 431, 435, and 457 in this rule propose the following policies:

- Amendments to part 430 subpart B propose electronic submission of state plans and plan amendments.

- Amendments to part 431 subpart A and part 433 subpart D propose updated, streamlined, and coordinated eligibility, beneficiary notice and appeal functions for Medicaid and CHIP.

- Amendments to part 435 subparts A, B, C and D reflect statutory changes to Medicaid eligibility. These amendments also add new or revised definitions and delete existing regulations that are rendered obsolete.

- Amendments to part 435 subparts E and F reflect statutorily-required changes to state procedures to verify citizenship or non-citizen status.

- Amendments to part 435 subpart G reflect the statutorily-required shift to MAGI-based financial eligibility methods for most populations, as set forth in the final Medicaid eligibility final rule issued on March 23, 2012 at (77 FR 17144).

- Amendment to part 435 subparts J and K and the addition of a new subpart M propose standards to promote the establishment by states of a seamless and coordinated system to determine eligibility of individuals seeking assistance and to enroll them in the appropriate insurance affordability program. Subpart M would delineate the responsibilities of the state

Medicaid agency in the coordinated system of eligibility and enrollment established under the Affordable Care Act. Comparable amendments would be made to CHIP requirements at part 457.

The proposed amendments to 45 CFR part 155 in this rule also propose requirements necessary to facilitate the creation of the Affordable Insurance Exchange eligibility and enrollment system established by the Affordable Care Act.

B. Provisions of the Proposed Rule

The following descriptions are structured to explain the provisions being proposed and do not necessarily follow the order of the regulation's text.

1. Appeals

(a). Generally (§§431.10, 431.205, 431.206, 431.221, 431.242, 431.244, 435.4, 435.907, 435.1200 and 45 CFR 155.302)

The Medicaid eligibility final rule published on March 23, 2012 at (77 FR 17144) ("Medicaid eligibility final rule"), along with the Exchange eligibility final rule published on March 27, 2012 (77 FR 18310), established a coordinated system of eligibility and enrollment in a QHP through the Exchange and for all insurance affordability programs, consistent with the Affordable Care Act. In this proposed rule, we propose modifications to Medicaid procedures, similar to those finalized in the Medicaid eligibility final rule, to promote coordination of notices and appeals of eligibility determinations. Consistent with sections 1413 and 2201 of the Affordable Care Act, the proposed revisions aim to coordinate Medicaid fair hearings under section 1902(a)(3) of the Act with appeals of eligibility determinations for enrollment in a QHP and for advance payment of the premium tax credit and cost-sharing reductions under section 1411(f) of the Affordable Care Act. Under the authority of section 1943(b)(3) of the Act, we propose to provide states with options for coordinating appeals to align with the options they have for eligibility determinations.

To promote coordination of appeals when there are appeals of both the level of advance payment of the premium tax credit or cost-sharing reductions granted for enrollment in a QHP through the Exchange and a denial of Medicaid, we propose at §431.10(c)(1)(ii) to permit Medicaid agencies to delegate authority to conduct fair hearings of eligibility denials based on the applicable modified adjusted gross income (MAGI) standard to an Exchange or Exchange appeals entity (hereinafter, when we refer to a delegation of authority to conduct Medicaid fair hearings to an Exchange, we also intend this reference to include delegation to an Exchange appeals entity), provided that individuals are given the option to have the fair hearing on the Medicaid denial conducted instead by the Medicaid agency. Proposed §431.206(d) directs that states delegating authority to conduct fair hearings to an Exchange must inform individuals of their right to opt instead for a fair hearing before the Medicaid agency and the method by which the individual may do so. Individuals would be informed of the option to opt into having the appeal heard by the Medicaid agency at the time the appeal is filed, prior to either entity conducting a hearing, and the notice provided would need to be sufficient to enable an informed choice.

The beneficiary option is required by statute, but we expect that most individuals will not opt out of having a consolidated appeal of both Medicaid and Exchange-related issues before the Exchange appeal entity, to choose instead to have two separate hearings (one before the Exchange appeals entity and one before the Medicaid agency). If the Exchange appeals entity conducts the hearing on the Medicaid denial, that hearing decision would be final under the proposed rule, subject to the state's option, proposed at §431.10(c)(3)(iii) and discussed further below, to review conclusions of law made by the hearing officer.

An Exchange appeals entity, defined at proposed §431.10(a)(2), would include a State-based Exchange appeals entity, as well as the HHS appeals entity, responsible for adjudicating appeals of determinations of eligibility to enroll in a QHP and for advance payment of the

premium tax credit and cost-sharing reductions under section 1411(f) of the Affordable Care Act. Per proposed §431.10(c)(2), delegation is permitted only to an Exchange that is a governmental agency that maintains merit protections for its employees. Delegation to a governmental agency is discussed in more detail at section I.B.12 of this proposed regulation, related to delegation of authority to conduct eligibility determinations. State Medicaid agencies may not delegate authority to conduct fair hearings to other state agencies, such as a sister human services agency or independent state appeals agency, under §431.10(c)(1)(ii). States may, however, request a waiver under the Intergovernmental Cooperation Act of 1968, as codified at 31 U.S.C. § 6504, as some states have done in the past. We note that these waivers, which may be requested by submitting a State Plan Amendment (SPA), are subject to the state establishing clear oversight over the agency conducting the fair hearings, similar to the standards set forth in §431.10(c) and (d).

Medicaid agencies may delegate authority to conduct fair hearings to a State-Based Exchange that is also a state agency either under the proposed regulations or by requesting a waiver under the Intergovernmental Cooperation Act of 1968. The primary difference would be that, under the waiver approach, the state would not be required to provide individuals with the option to have the Medicaid agency conduct their fair hearing. We seek comments on whether Medicaid agencies should have authority under the regulations to delegate fair hearing authority to any state agency, subject to the same limitations as those proposed for delegations to a state-based Exchange.

For states choosing to delegate Medicaid fair hearing authority to the Exchange, we propose at §431.10(c)(3)(iii) to provide states with an additional option under which the Medicaid agency would review decisions made by the Exchange with respect to Medicaid-related conclusions of law, including interpretations of state or federal policies. This option would not extend to reviewing factual determinations made by the Exchange appeals entity's

hearing officer. Any such review by the Medicaid agency would need to be accomplished in time for a final decision to be made in accordance with §431.244 of this part.

Under proposed §431.10(c)(1)(ii), the agency must specify in the state plan whether it is delegating authority to conduct fair hearings to the Exchange and the scope of the delegated authority (for example, if delegation is limited to fair hearings for individuals determined ineligible for Medicaid by the Exchange or whether the delegation includes individuals determined ineligible by the Medicaid agency). We note that an Exchange must agree to any delegation of authority and we do not expect that either the federally-facilitated Exchange (FFE) or the HHS appeals entity will accept delegated authority to adjudicate appeals of any Medicaid eligibility determinations which were not made by the FFE due to resource constraints.

We propose at §431.10(c)(3) that any delegation of fair hearing authority to the Exchange would be subject to safeguards to protect the integrity of the appeals process, such that beneficiaries receive the same due process rights and substantive review of their case as is provided in hearings conducted by the Medicaid agency. The Medicaid agency also would exercise appropriate oversight over the delegated hearing process, and take corrective action if necessary. We propose at §431.10(d) that a delegation of fair hearing authority would be effectuated through a written agreement specifying the respective roles and responsibilities of the Medicaid agency and Exchange to ensure compliance with the fair hearing requirements in subpart E, quality control and oversight by the Medicaid agency, including any reporting requirements to support the Medicaid agency's oversight, as well as assurances that the Exchange will comply with the terms of the delegation required under the proposed regulation.

In support of the proposed policy, we also propose to revise §431.10(a) to add definitions of "Medicaid agency," "appeals decision," "Exchange" and "Exchange appeals entity" at §431.10(a)(2), and to make conforming changes to existing regulations at §431.205(b)(1) to reflect the possibility of delegated appeals authority to an Exchange. We propose to delete the

requirements currently at §431.10(e)(2) and §431.10(e)(3), as these provisions are not consistent with the option to delegate appeals. However, we are retaining the current requirement at §431.10(e)(1), redesignated at proposed §431.10(e), that only the single state agency may supervise the plan and/or issue policies, rules and regulations on program matters.

We note that we also have streamlined and reorganized the text of the paragraphs concerning the procedures and safeguards required to permit delegation of eligibility determinations at §431.10 in this proposed rule. These revisions, promulgated in the Medicaid eligibility final rule to strengthen the authority and oversight of the Medicaid agency, are not intended to substantively change the policy adopted in that final rule.

In order to maximize coordination of appeals involving different insurance affordability programs and minimize burden on consumers and states, regardless of whether the Medicaid agency has retained the authority to conduct Medicaid appeals or delegated such authority to an Exchange, we propose revisions to existing regulations at §431.221 (relating to requests for a hearing), §431.244 (relating to hearing decisions) as well as to §435.4 (modifying the definition of "electronic account") and §435.1200 (relating to the Medicaid agencies' responsibility to ensure a seamless and coordinated system of eligibility and enrollment between all insurance affordability programs).

Specifically, we propose to add new paragraph (e) to §431.221 to provide that the Medicaid agency treat an appeal of a determination of eligibility for enrollment in a QHP in the Exchange and for advance payment of the premium tax credit or cost-sharing reductions, as a request for a fair hearing of the denial of Medicaid. This revision is intended to avoid the need for an individual to request multiple appeals. For example, an individual who is denied Medicaid and determined eligible for enrollment in a QHP with a certain level of advance payment of the premium tax credit and cost-sharing reductions may believe she should receive more assistance, but may not know in which program she belongs. So that individuals in this

situation do not have to submit two appeals or hearing requests – one to the Exchange appeals entity and one to the Medicaid agency – we propose in §431.221(e) that if such individual appeals the advance payment of the premium tax credit or cost-sharing reductions level, this appeal will automatically be treated as an appeal of the Medicaid denial, without the individual having to file a separate fair hearing request with the Medicaid agency. We are considering whether a later effective date of this provision, such as January 1, 2015, is appropriate to provide states with sufficient time to operationalize the proposed policy.

When the Medicaid agency has delegated the authority to conduct fair hearings to the Exchange and the individual does not opt to have the Medicaid hearing conducted by the Medicaid agency, this appeal of the Medicaid denial will be adjudicated by the Exchange appeal entity. However, where the Exchange appeal entity is not adjudicating the Medicaid appeal either because the individual opts to have a hearing at the Medicaid agency or the state has not delegated to the Exchange the authority to conduct hearings, we propose at §431.244(f)(2) that a decision of the Medicaid fair hearing may be issued within 45 days from the date the Exchange appeals entity issues its decision relating to eligibility to enroll in a QHP and for advance payment of the premium tax credit and cost-sharing reductions.

In making this proposal, we are attempting to balance the interest of the individual in receiving a timely Medicaid hearing decision with the recognition that, in many cases, Medicaid fair hearings triggered automatically by appeals related to advance payment of the premium tax credit and cost-sharing reductions will involve individuals with income significantly over the applicable Medicaid income standard, who are unlikely to be found eligible for Medicaid as a result of the appeal. In states that have not delegated authority to the Exchange to conduct fair hearings, or for individuals who opt to have a fair hearing before the Medicaid agency, waiting to conduct the Medicaid fair hearing until the Exchange appeals entity has concluded its hearing may reduce burden on all parties in these cases. Doing so will give the Medicaid agency the

benefit of the factual record developed by the Exchange appeals entity, avoiding the potential for duplicative, overlapping requests for additional information from the individual. In addition, permitting the appeals to be sequenced in this way will enable individuals satisfied with the adjudication their Exchange appeal, as well as those with income significantly above the Medicaid income standard, to withdraw their Medicaid fair hearing request. This is similar to how an individual may withdraw their application for Medicaid when accepting an advance payment of the premium tax credit under 45 CFR 155.302(b)(4) during an initial eligibility determination. We envision that the withdrawal of the appeal would be permitted in all modalities listed in §435.907(a). Withdrawal of a Medicaid fair hearing request could be effectuated through a simple process, for example by checking a box on information provided with the Exchange appeals decision or in connection with the steps the individual needs to take to accept advance payment of the premium tax credit and effectuate enrollment in a QHP. If the opportunity for withdrawal of the Medicaid fair hearing is not provided electronically initially due to operational constraints, it could be provided by telephone, through paper notification, or other commonly available electronic means, such as email.

We recognize that there will be situations in which consumers' interests would be better served by the Medicaid agency initiating the Medicaid fair hearing process simultaneously with the Exchange appeal – such as in the case of an individual determined eligible for advance payment of the premium tax credit and cost-sharing reductions at an income level relatively close to the applicable Medicaid income standard – and, while this would be permitted, it would not be required, under the proposed rule. Recognizing the different interests of states and consumers in different situations, we considered a number of approaches to striking the optimal balance, including allowing 30 or 60 days, instead of the proposed 45 days, from the date the Exchange appeals entity makes its decision for the Medicaid agency to render its fair hearing decision; extending the 90 day timeframe generally permitted for fair hearing decisions to 120

days from the date the fair hearing was requested; allowing for a decision 45 days from the date of the Exchange appeals decision or 120 days from the date the individual requested a fair hearing, whichever is earlier; and not modifying the 90-day timeframe at all. We solicit comments on the different approaches.

Finally, we anticipate that the HHS appeals entity will have an informal resolution process that will serve as a first level of review prior to the Exchange appeals entity engaging in a formal hearing process, and State-based Exchange appeals entities will have the option to adopt such a process, as well. See 45 CFR §155.535, discussed in section III.A. of the preamble of this proposed rule. During this process, a review of the initial eligibility determination made by the Exchange will take place, and the individual will have the opportunity to submit additional evidence related to his or her appeal. States that do not delegate authority to conduct Medicaid fair hearings to the Exchange, will be able to utilize the informal resolution process at the Exchange, provided that if an individual has requested a fair hearing, including a fair hearing triggered automatically to the Medicaid agency as a result of an appeal related to advance payment of the premium tax credit and cost-sharing reductions, the fair hearing before the agency also proceeds automatically if the informal process does not result in an approval of Medicaid eligibility. An informal resolution process at the Exchange could resolve a number of individual's appeals without conducting a fair hearing at the Medicaid agency, even if a state has not delegated authority to have fair hearings conducted at an Exchange. Use of the informal resolution process, which would be specified in the agreement between the Medicaid agency and the Exchange consummated in accordance with §435.1200(b)(3), would not affect the timeliness requirements for a final hearing decision in §431.244.

We propose to revise the definition of "electronic account" in §435.4 of the Medicaid eligibility final rule to include information collected or generated as part of a Medicaid fair hearing process or Exchange appeals process, so that information generated or collected during

an appeal and any appeals decisions will be transferred between programs as part of the individual's electronic account. To align with that new definition, we modify §431.242(a)(1)(i) by adding that individuals have access to an electronic account, as they currently have access to a "case file."

In situations in which the Medicaid agency has delegated to the Exchange authority to make eligibility determinations and to conduct Medicaid fair hearings, we propose revisions at §435.1200(c) to clarify that the Medicaid agency must receive and accept a decision of the Exchange appeals entity finding an individual eligible for Medicaid just as it accepts determination of Medicaid eligibility made by the Exchange Moreover, as provided in the proposed revisions to §435.1200(c), if the Exchange appeals entity to which Medicaid fair hearing authority has been delegated has adjudicated both an appeal of advance payment of the premium tax credit and cost-sharing reductions as well as a Medicaid denial, a combined appeals decision will be required.

We also propose modifications to §435.1200(d) originally added by the Medicaid eligibility final rule to streamline and coordinate processes when the Exchange does not determine but conducts an assessment of, potential Medicaid eligibility. Under 45 CFR 155.302(b)(4)(i)(A), when the Exchange conducts an assessment, and finds an individual potentially ineligible for Medicaid and eligible for advance payment of the premium tax credit, the Exchange will provide the individual with an opportunity to withdraw the Medicaid application. To ensure coordination across the entire eligibility, enrollment and appeals process, we propose to modify §435.907 by adding a new paragraph (h) to automatically reinstate the Medicaid application if the individual subsequently files an appeal related to the determination of their eligibility for enrollment in a QHP or for advance payment of the premium tax credit or cost-sharing reductions, and the Exchange appeals entity assesses the individual potentially eligible for Medicaid. Reinstatement of the application for Medicaid would be effective as of the

date the application was initially received by the Exchange. Once assessed as potentially Medicaid eligible by the Exchange appeals entity, the individual's electronic account would be transferred to the Medicaid agency per §435.1200(d) and the Medicaid agency would make a final determination. If the agency denies Medicaid, the individual would have the right to request a Medicaid fair hearing at that time. We note that this scenario would only arise in states that have not delegated to the Exchange the ability to conduct eligibility determinations under §431.10(c)(1)(i). (Revisions to 45 CFR 155.302(b)(4)(A) related to reinstatement of a withdrawn application are also proposed in this rulemaking and are discussed in section III.A. of the preamble.) We also note that, under the proposed Exchange regulation at 45 CFR 155.510(b), discussed in section III.A of the preamble, the assessment of Medicaid eligibility conducted by an Exchange appeals entity will be as comprehensive as that performed by the Exchange when making the underlying assessment of Medicaid eligibility under §155.302(b).

Under the proposed revisions to §435.1200(d)(2), we clarify that when a Medicaid agency is determining the eligibility of an individual who has been assessed as potentially eligible for Medicaid by an Exchange appeals entity, the Medicaid agency may not request information or documentation from the individual already provided in the electronic account, or to the applicable insurance affordability program or appeals entity; similarly, as clarified in §435.1200(d)(4), the agency must accept any finding relating to a criterion of eligibility made by another insurance affordability program's appeals entity if such finding was made in accordance with the same policies and procedures as those applied by or approved by the Medicaid agency. These procedures parallel those adopted in the Medicaid eligibility final rule with respect to eligibility determinations.

Similar to the revisions proposed at §435.1200(d), we also propose revisions to §435.1200(e)(1) to provide that when an individual has been determined ineligible for Medicaid pursuant to a fair hearing conducted by the Medicaid agency, the agency must assess the

individual for potential eligibility for other insurance affordability programs, just as it must do under §435.1200(e), as originally set forth in the Medicaid eligibility final rule for individuals determined ineligible for Medicaid by the agency at initial application or renewal.

Finally, we propose to add a new paragraph (g) to §435.1200, to ensure coordination between appeals entities. Proposed paragraph (g)(1), which would apply regardless of whether the Medicaid agency delegates authority to conduct any fair hearings to the Exchange, directs the Medicaid agency to establish a secure electronic interface through which:

- The Exchange appeals entity can notify the Medicaid agency that an appeal has been filed related to eligibility to enroll in a QHP and for advance payment of the premium tax credit and cost-sharing reductions when such appeal triggers an automatic Medicaid fair hearing request; and
- The individual's electronic account, including information provided by the individual to the Medicaid agency during the fair hearing process or the Exchange appeals entity can be transferred between programs or appeals entity.

Under proposed §435.1200(g)(1), the secure electronic interface established between the Medicaid agency and Exchange may be used for these purposes, or a separate secure interface directly between the Medicaid agency and Exchange appeals entity may be established; therefore this provision does not propose any new requirements on Medicaid agencies. When the Exchange appeals entity conducts a Medicaid fair hearing on an individual's Medicaid denial, no notification or transfer of information through such interface would be needed at the point the individual files the appeal.

Under proposed §435.1200(g)(2), the Medicaid agency must ensure that, as part of a Medicaid fair hearing conducted under part 431 subpart E, the Medicaid agency does not request information or documentation from the individual already included in the individual's electronic account or provided to the Exchange or Exchange appeals entity. We propose in

§435.1200(g)(3) that the Medicaid agency transmit its Medicaid fair hearing decision to the Exchange in two situations: (1) when an individual had been initially determined ineligible for Medicaid by the Exchange, in accordance with a delegation of authority under §431.10(c)(i); and (2) when an individual who was initially determined to be ineligible for Medicaid by the Medicaid agency had his or her account transferred to the Exchange under §435.1200(e) for evaluation of eligibility and financial assistance through the Exchange and the individual had a fair hearing conducted by the Medicaid agency. Because such individuals may have enrolled in a QHP through the Exchange and be receiving advance payment of the premium tax credit and/or cost-sharing reductions pending the outcome of the Medicaid fair hearing, the Exchange will need to know the outcome of the Medicaid fair hearing so that it will know whether to terminate or continue advance payment of the premium tax credit and cost-sharing reductions.

We also make conforming amendments to §435.1200(b) related to the coordination of appeals between the Medicaid agency and the Exchange and Exchange appeals entity. We propose to modify §435.1200(b)(1) to incorporate new paragraph (g) in the delineation of general requirements that the Medicaid agency must meet to effectuate a coordinated eligibility system and to revise §435.1200(b)(3)(i) to clarify that the goal of minimizing burden on consumers through coordination of insurance affordability programs also relates to coordination of appeals processes. Proposed revisions to §435.1200(b)(3)(ii) provide that the agreement entered into between the Medicaid agency and the Exchange must ensure compliance with new paragraph (g).

Finally, it is important to note that under the proposed Exchange regulations at 45 CFR 155.302(b)(5), if the decision made by the Exchange appeals entity conflicts with a decision made by the Medicaid agency regarding an individual's Medicaid eligibility, the decision of the Medicaid agency takes precedence and is binding on the Exchange, just as a determination of eligibility or ineligibility made by the Medicaid agency takes precedence over an assessment

made by the Exchange.

(b) Related changes to the Medicaid appeals process (§§431.200, 431.201, 431.205, 431.206, 431.211, 431.213, 431.220, 431.221, 431.224, 431.230, 431.231, 431.232, 431.240, 431.241, 431.242, and 431.244)

We propose the following modifications to our current fair hearing regulations at §431.200, et seq. to align with the changes described above, to modernize our regulations, and to clarify certain provisions consistent with the Medicaid eligibility final rule. We propose to:

- Revise §431.200 to list sections 1943(b)(3) of the Act and 1413 of the Affordable Care Act as statutory authority for establishing a system and procedures to coordinate eligibility, including eligibility appeals that result in a final decision about an individual's eligibility.

- Add a definition for "local evidentiary hearing" to §431.201 to clarify terminology in our regulations.

- Modify §431.220(a)(1) to clarify that a hearing is required when an applicant requests it because the Medicaid agency has denied the individual's eligibility, level of benefits, services, or claim or if the Medicaid agency has failed to act with reasonable promptness, as required by section 1902(a)(3) of the Act. We specify that a determination of eligibility would include, if applicable, a determination of a spend down liability or a determination of income used to impose any premiums, enrollment fees, or cost sharing under part 447 of this subchapter. We intend these modifications as clarifications and do not believe they reflect a change in policy. We modify the definition of action at §431.201, when information be provided at §431.206, and the issues to be considered at a hearing at §431.241(a) and (b) to align with the modification of §431.220 and do not believe that these changes reflect a change in policy.

- Modify §431.221 to allow an individual to request a hearing consistent with the ways in which an application may be filed: (1) by telephone; (2) by mail; (3) in person; (4) through other commonly available electronic means; and (5) at state option, via the Internet website at

§435.1200(f). We expect other commonly available electronic means to include requesting a fair hearing by e-mail, and could include facsimile or other electronic systems commonly available. In contrast to the final Medicaid eligibility rule policy related to filing applications and renewal forms at §§435.907 and 435.916, we have proposed using the Internet website at §435.1200(f) as a state option in light of the operations implications of requiring this method for requesting a hearing. We are considering instead making this option a requirement at a date sometime after January 2014 to allow time for implementation and we solicit comments on this proposal.

- Add §431.224, "Expedited Appeals" to align our fair hearing process at §431.200, et seq, with that already established for appeals in managed care at §438.410, to permit an individual who has an urgent health need to have their appeal addressed under expedited timeframes. We do not anticipate that this will be difficult to administer or significantly add to state costs as states can use existing mechanisms such as notices they are already issuing to individuals to implement this provision.

- Modify §431.231 to align the date an individual is considered to receive notice under this section with that proposed for the notice of reasonable opportunity period in proposed §435.956, discussed in section I.B.7 of the preamble, to promote consistency and ease of administration. We propose that the date on which the notice is received is considered to be 5 days after the date on the notice, unless the individual shows that he or she did not receive the notice within the 5-day period. Five days from the date of notice is the standard period used by Social Security Administration for the Supplemental Security Income (SSI) (Title XVI) and Old Age and Disability (Title II) programs to account for mailing a notice and receipt by the individual (see 20 CFR 416.1401, 20 CFR 404.901, respectively). This is also the standard used by the Exchange in 45 CFR 155.315(c)(3) regarding notices sent to resolve inconsistencies during the verification process for citizenship, status as a national, and lawful presence.

- Modify §431.232 to clarify that the agency will inform an applicant or beneficiary that

he or she has 10 days from the notice of an adverse decision of a local evidentiary hearing to appeal that decision. We also adopt in proposed §431.232 the language discussed above related to the date an individual is considered to receive notice.

- Modify §431.240 to specify that a hearing officer must have access to the agency's information, such as state policies and regulations necessary to issue a proper hearing decision, consistent with our proposed regulation to permit delegation of authority to the Exchange to conduct fair hearings at §431.10(c) and (e).

- Modify §431.242 to align our regulations related to individual's ability to review an individual case file, to include an individual's ability to review his or her electronic account, as defined at §435.4.

- Modify existing regulations at §431.244(f)(1) to clarify that the 90-day timeframe to issue a decision after an individual files an appeal applies broadly to appeals decisions, not only to managed care appeals decisions. This text was inadvertently deleted in a previous rulemaking. This codifies this long-standing policy and does not reflect a change in policy.

- Revise §431.244(f)(2) to modify the appeals decision timeframe to account for the expedited appeals process being proposed at §431.224, aligning with the existing expedited decision process for managed care appeals decisions at §431.244(f)(2) and (f)(3).

(c). Applicability to CHIP (§§ 457.10, 457.340, 457.348, 457.350, 457.1180, 457.351)

Revisions to the regulations for CHIP are proposed to achieve similar coordination of appeals among insurance affordability programs and to minimize burden on consumers. Regulations governing the CHIP appeals, or "review" process, are set forth at subpart K of part 457 of the current regulations. Under §457.1120, states currently have broad flexibility to delegate the CHIP review process, and no revision to permit delegation of review authority to the Exchange or Exchange appeals entity is needed. To effectuate the same coordination of CHIP appeals with other insurance affordability programs, as is proposed with respect to Medicaid fair

hearings, a new §457.351 (Coordination involving appeals entities for different insurance affordability programs) is proposed. Conforming changes to existing CHIP regulations are also proposed.

- Under §457.10, we propose to revise the definition of electronic account to include any information collected or generated as part of a review, and to add the definition of exchange appeals entity, similar to the revision to the definition in the Medicaid regulations at §435.4.

- Section 457.340 (Application for and enrollment in CHIP) is revised to include provision of notice of an individual's right to review, consistent with §457.1180 and to apply §435.907(h), proposed for addition to the Medicaid regulation in this rulemaking (Reinstatement of withdrawn applications) to CHIP.

- Section 457.348, related to the provision of CHIP for individuals found eligible by other insurance affordability programs, is revised to include individuals found eligible as a result of a decision made by the Exchange appeals entity authorized by the state to adjudicate reviews of CHIP eligibility determinations, similar to the revisions proposed for the Medicaid regulations at §435.1200(c) and to apply the provisions for transfer of information via secure electronic interface, similar to the revisions proposed for Medicaid regulations at §435.1200 (d).

- Proposed revisions to §457.350 apply the rules for eligibility screening and enrollment in other insurance affordability programs to individuals determined not eligible for CHIP pursuant to a review conducted in accordance with subpart K of this part, similar to the revisions proposed for the Medicaid regulations at §435.1200(e).

- Section 457.1180 is revised to propose that states treat an appeal to the Exchange appeals entity of a determination of eligibility for advanced payments of the premium tax credit

or cost-sharing reductions as a request for a review of a denial of CHIP eligibility, if the individual was denied eligibility for CHIP by the state or other entity authorized to make such determination, similar to the revisions proposed for the Medicaid regulations at §431.221(e).

2. Notices

An effective notification process is important to a high quality consumer experience and a coordinated eligibility and enrollment system, as provided for under section 1413 of the Affordable Care Act and section 1943 of the Act. Without revisions to current regulations, many individuals could receive multiple, uncoordinated notices from the different programs. Someone applying through the Exchange who is assessed as potentially eligible for Medicaid, for example, could receive a notice from both Medicaid (approving Medicaid) and the Exchange (denying advance payment of the premium tax credit and cost-sharing reductions). Under current rules, if the Medicaid agency disapproves rather than approves eligibility for an individual assessed by the Exchange as potentially Medicaid eligible, the individual could receive 3 notices (from the Exchange denying advance payment of the premium tax credit and cost sharing reductions, from the Medicaid agency denying Medicaid, and subsequently from the Exchange reversing its earlier denial of advance payment of the premium tax credit and cost sharing reductions).

To avoid confusion for consumers and duplicative administrative activity we propose that, to the maximum extent feasible, state Medicaid and CHIP agencies and the Exchange produce a single combined notice after all MAGI-based eligibility determinations have been made. We are also proposing to add basic content and accessibility standards for all eligibility notices, and to ensure that electronic eligibility notices are available as an option for applicants and beneficiaries. To ensure that the federal rules for all programs are aligned, we are proposing similar regulations for the Exchange. See §155.230 and §155.345, discussed in section III of the preamble. However, as described below, given the time needed to allow for systems builds, the requirement to provide a combined eligibility notice will not be effective until January 1, 2015.

(a) Content and accessibility standards (§435.917 and §435.918)

We are proposing to redesignate and revise §435.913 at proposed §435.917 to clarify the state agency's responsibilities to communicate specific content in a clear and timely manner to applicants and beneficiaries when issuing either a notice of approved eligibility or a notice of denial or other adverse action. We also propose to delete §435.919 and to move the provisions now contained therein to proposed §435.917.

Per proposed §435.917(a), eligibility notices must be written in plain language and be accessible to individuals who are limited English proficient and individuals with disabilities and comply with regulations relating to notices in part 431 subpart E and, if provided in electronic format, with §435.918, newly proposed in this rulemaking. Notices of an approval of Medicaid eligibility must include clear and specific content, as specified in proposed §435.917(b)(1). Proposed §435.917(b)(2) cross references §431.210 for the specific notice content required for an adverse action – including a denial, termination, suspension of or change in eligibility, or a change in benefits or services. Revisions to §431.210 are proposed to achieve similar clarity and transparency for notices of adverse actions as are proposed for notices of an approval of Medicaid eligibility. We note that a citation of the specific regulation(s) that support the action, as required by §431.210(c), does not satisfy the requirement to provide "a clear statement" explaining the adverse action under §431.210(a), as revised in this proposed rulemaking. CMS will work with states and other stakeholders to develop model notices meeting the requirements of the regulations.

Proposed §435.917(c) directs that all eligibility notices relating to a determination of eligibility based on the applicable MAGI standard include a plain language description of other bases of eligibility (such as disability, long-term care services need, or incurred medical expenses for medically needy coverage) as well as the level of benefits and services to which someone eligible on such other bases is entitled. The information provided must be sufficient to

enable individuals to make an informed decision as to whether or not to seek a determination of eligibility on a MAGI-excepted basis. We note that both individuals who are approved for, as well as those who are denied, Medicaid on the basis of the applicable MAGI standard should be provided the information specified, as eligibility on another basis may better meet the individual's needs. We solicit comments on the level of detail which should be required for inclusion in the notice under §435.917(c).

Current notice regulations require paper-based, written notices. New proposed §435.918 would maintain the requirement for paper-based written notices, but would also require states to provide individuals with the option to receive notices through a secure electronic format in lieu of written notice by regular mail, which remains the default method of notice provision. Per proposed §435.918, after an individual elects electronic notification, the agency would send a paper notification informing the individual of his or her election to receive eligibility notices electronically. The agency would post notices to the individual's secure electronic account, notifying the individual by text message, email, or other electronic communication that a notice had been posted and directing the individual to check his or her account. We considered permitting individuals applying on-line to provide electronic confirmation of their election, but believe that confirmation via regular mail provides stronger consumer protection. We welcome comment on this, and other consumer safeguards for electronic notification. Also, we recognize that in addition to eligibility notices, there are other communications that occur between the applicant/beneficiary and the Medicaid or CHIP agency. These communications include requests for additional information, annual renewal forms and reminders, premium payment information, changes in benefits or covered services, etc. We are considering whether all or some of these should be available to the consumer electronically by posting to the electronic account and seek comment.

As described above, newly proposed §435.917(a), which establishes content and accessibility standards for Medicaid notices, requires that notices comply with the provisions in §435.918, if provided in electronic format. In addition, paragraph (c)(5), which is proposed for addition to §431.206, relating to the agency's responsibility to inform applicants and beneficiaries of adverse actions, includes a provision to permit electronic notices consistent with §435.918. We have also modified §§431.211, 431.213, 431.230, and 431.231 to update and modernize the language in the regulation to remove the term "mail" and instead use "send," which will still require states to provide paper-based written notices, but also permit states to offer beneficiaries the option of receiving notices electronically, after obtaining consent from the individual, consistent with the consumer protections in proposed §435.918.

(b) Provision of Coordinated Notice—Medicaid Agency Responsibilities (§435.1200)

We propose revisions to the Medicaid eligibility final rule to provide for a coordinated system of notices across all insurance affordability programs based on MAGI, regardless of where the individual initially submits an application or whether the Exchange is authorized to make Medicaid and CHIP eligibility determinations. Under the proposed rule, to the maximum extent feasible, individuals will receive a single notice communicating the determination or denial of eligibility for all applicable insurance affordability programs and for enrollment in a QHP through the Exchange, rather than separate notices from the Medicaid and/or CHIP agencies and the Exchange.

Our proposal is effectuated primarily in revisions to §435.1200, as published in the Medicaid eligibility final rule. In support of our proposed policy, we also propose to add definitions of "combined eligibility notice" and "coordinated content," in §435.4. "Combined eligibility notice" is an eligibility notice that informs an individual, or household when appropriate, of his or her eligibility for multiple insurance affordability programs, including all or most of the information required for inclusion per proposed §435.917 and §431.210, as

revised in this proposed rule. "Coordinated content" refers to information included in an eligibility notice relating to the transfer of the individual's electronic account to another program, and the status of that other program's review of the account. Coordinated content will be important when the eligibility determination for all programs cannot be finalized for inclusion in a single coordinated notice.

In §435.1200, we propose adding sub paragraph (b)(3)(iv) to provide that the agreements between the Medicaid agency and other insurance affordability programs delineate the responsibilities of each program to provide combined eligibility notices and coordinated content, as appropriate. We note that under these agreements, the Medicaid and CHIP agencies and the Exchange must work together to provide, to the maximum extent possible, a single combined notice of eligibility that includes all family members of the same household applying for coverage together. We include at paragraph (d) of proposed §435.917, discussed generally in section I.B.2.a of the preamble, above, that the agency's responsibility to provide an eligibility notice is satisfied by a combined notice provided by the Exchange or another insurance affordability program pursuant to an agreement between the agency and the Exchange or such program.

We propose to add sub paragraph (3) to §435.1200(c) to provide that when the Exchange or other agency administering an insurance affordability program is authorized to, and does make, a determination of Medicaid eligibility, the agreement described in paragraph (b)(3) stipulates that the Exchange or other agency will provide the applicant with a combined eligibility notice including information about the individual's Medicaid eligibility (approval or denial). For example, if the Exchange receives an application and determines the applicant eligible for Medicaid, the Exchange will issue a combined notice including information related both to the approval of Medicaid eligibility and the denial of eligibility for advanced payments of the premium tax credit and cost-sharing reductions.

We propose for clarity to redesignate paragraph §435.1200 (d)(5) at paragraph (d)(2) and to redesignate the other paragraphs of paragraph (d) accordingly. We further propose to revise redesignated §435.1200(d)(4) to add new language at clause (d)(4)(i) to specify that, when an individual is assessed by the Exchange or other program as potentially Medicaid eligible and is transferred to the Medicaid agency for a final determination, if the Medicaid agency approves eligibility, the Medicaid agency will provide the combined eligibility notice for all applicable programs. For example, if the Exchange assesses an individual as potentially Medicaid eligible and transfers the individual's electronic account to the Medicaid agency, and the agency approves eligibility, the agency would issue a combined notice, including information related to the approval of Medicaid eligibility as well as the denial of eligibility for advance payment of the premium tax credit and cost-sharing reductions.

Finally, we propose revisions to §435.1200(e) to provide at new paragraph (e)(1)(ii) that the Medicaid agency include in the agreement consummated under §435.1200(b)(3) that the Exchange or other program will issue a combined eligibility notice, including the Medicaid agency's denial of Medicaid eligibility, for individuals denied eligibility by the agency at initial application (or terminated at renewal) and assessed and transferred to the Exchange or other insurance affordability program as potentially eligible for such program. For example, if the Medicaid agency determines that an individual is not Medicaid eligible, but transfers the individual's account to the Exchange as potentially eligible for enrollment in a QHP, the Exchange would issue a combined notice of the individual's eligibility for enrollment in a QHP, advance payment of the premium tax credit, cost-sharing reductions, and the denial of Medicaid.

Our proposed policy of a single combined eligibility notice does not apply in the case of individuals determined eligible on a basis other than MAGI, because the Medicaid agency may be continuing its evaluation of an individual's eligibility on such other bases at the same time that the individual is being evaluated for, or is enrolled in, another insurance affordability

program pursuant to §435.911(c)(2) of the Medicaid eligibility final rule. In such cases, while a single, combined notice containing the agency's final determination on all bases would not be required, per proposed §435.1200(e)(2)(ii), the Medicaid agency would provide notice to the individual, in accordance with §431.210(a) and §435.917, that the agency has determined the individual ineligible for Medicaid on the basis of MAGI, and that the agency is continuing to evaluate Medicaid eligibility on other bases. Under the proposed regulation, this notice also would contain coordinated content advising the applicant that the agency has assessed the individual as potentially eligible for, and transferred the individual's electronic account to, another program. Proposed §435.1200 (e)(2)(iii) requires the agency to provide the individual with notice of the final eligibility determination on the non-MAGI bases considered. If the individual is later determined eligible for Medicaid on a basis other than MAGI, the individual would receive a combined notice that includes information of the approval of Medicaid eligibility and ineligibility for advance payment of the premium tax credit and cost-sharing reductions.

There are a few additional situations we have identified under the proposed regulation in which a single notice will not be required—in such situations notices would include coordinated content appropriate to the situation. First, when an individual who is assessed by the Exchange as not potentially Medicaid eligible based on MAGI and determined eligible for advance payment of the premium tax credit and cost-sharing reductions, a notice of eligibility for advance payment of the premium tax credit and cost-sharing reductions (issued by the Exchange) will be needed. If the individual requests a full determination of Medicaid or CHIP eligibility by the state agency, as permitted under the Exchange final regulation at §155.302(b)(4)(B), a second notice will be needed once the Medicaid or CHIP agency has made a decision on the application. Depending on whether the state agency approves or denies Medicaid or CHIP, either a

coordinated notice or coordinated content with information relating to the individual's eligibility for advance payment of the premium tax credit and cost-sharing reductions will be needed.

Second, when different members of the same household are determined eligible for different programs, a single combined notice for all members of the household may not be feasible. In such situations, as described in §435.1200(b)(4), notices would include appropriate coordinated content related to the status of other members of the individual's household. We welcome comments as to whether there are other situations, besides the two situations identified, when a combined eligibility notice is not feasible.

We also note that, in consultation with states, consumer groups and plain-language experts, we intend to develop language to be released in 2013, which could be adapted by states as a model for delivering combined eligibility notices. Because some states have specific content which will need to be included in notices issued by an Exchange in their state, state Medicaid and CHIP agencies will work with the Exchange on any state-specific content to be included in a combined notice and/or may issue supplementary notices if the Exchange is unable to deliver all required state-specific content.

Finally, given the time needed to allow for systems builds, we are proposing that the policy to provide a combined eligibility notice will not be effective until January 1, 2015. At state option, based on the operational readiness of all programs, combined eligibility notices may be implemented earlier. States with an FFE will only be able to provide a combined eligibility notice prior to January 1, 2015 for eligibility determinations made by the FFE. In the absence of a combined eligibility notice, coordinated content ensures that applicants and beneficiaries are informed of the status of their application with respect to other insurance affordability programs. We also considered a later effective date of October 15, 2015 for the requirement to provide a combined eligibility notice in all circumstances provided for in the proposed rule, which would

coincide with the beginning of open enrollment for January 2016. We welcome comments on the proposed effective date of January 1, 2015 and the later effective date of October 15, 2015.

We also make a technical correction to §435.1200. We update paragraph (a) to correct an erroneous statutory citation.

(c) CHIP Eligibility Notices and Information Requirements (§§457.10, 457.110, §457.340, 457.348 and 457.350)

We propose to modernize and amend the existing CHIP regulations pertaining to notices at §457.110 and §457.340(e) to correspond to the regulation changes and additions proposed for Medicaid at §435.917, and §435.918. We also propose to add a definition of "combined notice" and "coordinated content" in §457.10 and to revise paragraphs (a), (b), (c) and (d) of §457.348 and paragraphs (f) and (i) in §457.350 to mirror the proposed revisions to the Medicaid regulations in §435.1200 (b), (c), (d), and (e) to maximize achievement of a system of coordinated notices across all insurance affordability programs, including CHIP.

Per proposed §457.350(f)(3), we seek to clarify that the requirement that a state find an individual ineligible, provisionally ineligible, or suspend the individual's application for CHIP unless and until the Medicaid application for the individual is denied applies only at application. We propose to clarify this provision in response to concerns expressed by states that if this provision is applied to CHIP enrollees at redetermination, a gap in coverage could result.

We also propose to update §457.350(g), relating to the states' responsibility to provide information to CHIP applicants regarding the Medicaid program, to extend to all insurance affordability programs. We also propose to update §457.350(h)(2), which describes the state's responsibility to inform a CHIP applicant on a waiting list that if circumstances change, the applicant may be eligible for other insurance affordability programs, in addition to Medicaid, so that the Exchange, Medicaid, and CHIP can work together to ensure that eligible applicants are enrolled in the appropriate program.

A technical correction is made to §457.350(b). We update paragraph (b) to clarify that the requirement to screen for potential eligibility for other insurance affordability programs applies to any applicant or enrollee who submits an application or renewal form to the state which included sufficient information to determine CHIP eligibility. This includes not only those determined ineligible for CHIP but also individuals subject to a waiting period or those screened as not potentially eligible for Medicaid based on MAGI and enrolled in CHIP but also assessed as potentially eligible for Medicaid on another basis and referred to the Medicaid agency for a full Medicaid determination.

3. Medicaid Eligibility Changes under the Affordable Care Act

(a) Former Foster Care Children (§435.150)

Sections 2004 and 10201(a) and (c) of the Affordable Care Act add a new section 1902(a)(10)(A)(i)(IX) of the Act, under which states must provide Medicaid coverage starting in 2014 for individuals under age 26 who were in foster care and receiving Medicaid. Note that states still have the option to cover a similar eligibility group for independent foster care adolescents, which has slightly different requirements (see §435.226 of this proposed rule).

Consistent with the statute, we propose to add §435.150 establishing this new mandatory eligibility group for individuals who:

- Are under age 26;
- Are not eligible for and enrolled in mandatory Medicaid coverage under sections 1902(a)(10)(A)(i)(I) through (VII) of the Act, eligibility under which is codified in §§435.110 through 435.118 and §§435.120 through 435.145 of subpart B of the regulations; and
- Were in foster care under the state's or tribe's responsibility (whether or not under title IV-E of the Act) and also enrolled in Medicaid under the state's Medicaid state plan or 1115 demonstration (or at state option were in foster care and Medicaid in any state rather than "the" state where the individual is now residing and applying for Medicaid) when the individual

attained age 18 or such higher age at which the state's federal foster care assistance ends under title IV-E of the Act.

We are proposing an interpretation of the statute that an individual qualifies for this mandatory Medicaid coverage if the individual was concurrently enrolled in foster care and Medicaid either when attaining age 18 or at the point of "aging out" of foster care. This interpretation is based on the statute's use of the word "or" to permit either alternative. We considered a different interpretation that would limit eligibility to individuals who "age out" of foster care. Among the states that have extended foster care programs beyond age 18, all but two states end foster care at age 21.

The statute requires that an individual be in foster care under the responsibility of "the state" and be enrolled in Medicaid under "the state plan" or an 1115 demonstration. In this proposed rule, we are interpreting that requirement as meaning that the individual was in foster care and enrolled in Medicaid in the same state in which coverage under this eligibility group is sought. However, we are proposing to give states the option to cover individuals under this group who were in foster care and Medicaid in any state at the relevant point in time. We request comments on this interpretation of the statute.

In accordance with the statute, there is no income or resource test for this group. Individuals may apply and be determined eligible at any time between attaining age 18 and losing eligibility under this group upon attaining age 26. In accordance with longstanding general Medicaid policy clarified at §435.916(f) of the Medicaid eligibility final rule, when an individual loses eligibility under this group, coverage shall not be terminated unless the individual is not eligible under any other group (for example, the new adult group at §435.119 of the Medicaid eligibility final rule.)

Eligibility under the adult group at §435.119 of the regulations (as specified in the March 23, 2012 Medicaid eligibility final rule) will not take precedence over coverage under the

mandatory group of former foster care children. In accordance with the second subclause (XVI) in the matter following subparagraph (G) of section 1902(a)(10) of the Act, as added by section 10201(a)(2) of the Affordable Care Act, individuals eligible for both the former foster care group and the adult group should be enrolled in the former foster care group.

(b) Financial Methodologies for Individuals Excepted from Application of MAGI-Based Methodologies (§435.601 and §435.602)

Due to changes in the Affordable Care Act, we propose technical amendments to §435.601(b) and §435.602(a) to specify that these sections, related to general application of financial eligibility methodologies and financial responsibility of relatives and other individuals, only apply to individuals excepted from application of the MAGI-based methodologies in accordance with §435.603(j). Also, as required by section 1902(e)(14)(B) of the Act, which prohibits income disregards other than those expressly included in MAGI methodologies for the MAGI-related populations, we propose to amend paragraph (d) of §435.601 to remove "MAGI-related" eligibility groups (financial eligibility for which will be determined using MAGI-based methodologies set forth in §435.603) from the groups to which a state may use the authority of section 1902(r)(2) of the Act to adopt less restrictive income and resource methodologies than those under the most-closely related cash assistance program.

(c) Family Planning (§435.214)

Section 2303 of the Affordable Care Act adds new sections 1902(a)(10)(A)(ii)(XXI) and 1902(ii) of the Act, as well as the first new clause (XVI) in the matter following 1902(a)(10)(G) (there are two paragraph (XVI)s; the first is the one related to family planning), under which states have the option to provide Medicaid coverage to women and men that is limited to family planning or family planning related services under the state plan.

Consistent with the statute, we propose to add §435.214 establishing this new eligibility group for individuals who:

- Are not pregnant;
- Have income that does not exceed the income eligibility level established by the state, as discussed below. Section 1902(ii)(1) specifically allows for income eligibility up to the highest income eligibility level established by the state for pregnant women in the Medicaid or CHIP state plan. We have interpreted this to also include the income level established by the state for pregnant women under the state's Medicaid or CHIP demonstration approved under the authority of section 1115 of the Act.

Because section 1902(e)(14) applies a "notwithstanding any other provision of Title XIX," and individuals eligible for family planning are not an exempt group listed at 1902(e)(14)(D), beginning January 1, 2014, financial eligibility for this group will be determined using the MAGI-based methodologies set forth at §435.603 of the regulations. However, section 1902(ii)(3) of the Act, permits states to consider only the income of the individual applying for family planning benefits in determining eligibility under this section. Accordingly, at §435.603 we are proposing to codify the current policy outlined in the July 2, 2010 state Medicaid Director Letter (http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10013.pdf). Under this policy about determining financial eligibility for the new eligibility group at proposed §435.214, states may consider the individual's household to consist only of the individual, may consider only the income of the individual applying for coverage (while retaining other members of the household for purposes of determining family size), and may increase the family size used for determining eligibility for coverage under this group by one, similar to the increase in family size for pregnant women.

Finally, we are proposing to amend the definition of a targeted low income child at §457.310(b)(2) to indicate that eligibility for limited coverage of family planning services under §435.214 does not preclude an individual from being eligible for CHIP. In circumstances where

an individual is enrolled in both CHIP and Medicaid family planning coverage, Medicaid would be secondary payer to CHIP in accordance with 1902(a)(25) of the Act and 42 CFR 433 Subpart D.

4. Medicaid Enrollment Changes under the Affordable Care Act needed to achieve coordination with the Exchange

(a) Certified Application Counselors (§435.908 and §457.330)

Some individuals require assistance with completing an application, enrolling in coverage or with ongoing communications with the agency once determined eligible. While many may seek informal assistance with applications from friends or relatives, others may seek assistance from trusted community-based organizations, providers, or other organizations with expertise in social service programs. Staff and volunteers from such organizations provide important assistance in completing application and renewal forms, and in explaining and helping individuals to meet any documentation requirements, but do not sign forms, receive notices or other communications, or otherwise act on behalf of the individual being assisted. Individuals able to perform those types of functions (often a family member, legal guardian, or attorney) are referred to as "authorized representatives" and are discussed in the next section, below.

Many state Medicaid and CHIP agencies have a long history of enabling providers and other organizations to serve as "application assisters," which we refer to in this proposed rulemaking as "application counselors" to provide such direct assistance to individuals seeking coverage, and these counselors play a key role in promoting enrollment among low-income individuals. These proposed regulations seek to ensure that application counselors, who we expect to continue to play an essential role in many states, will have the training and skills necessary to provide reliable, effective assistance to consumers, and that they will meet the confidentiality requirements that apply to the data they will be able to access in their role as

assisters, including those established in accordance with section 6103 of the Internal Revenue Code and section 1902(a)(7) of the Act.

We anticipate that, beginning with the initial open enrollment period, an increasing number of individuals will seek to apply for coverage on line, and while some states already have web infrastructure which allows application counselors to track their clients' applications and manage caseloads, we expect that practice to increase as states improve their electronic application systems. Other applicants may still submit applications on paper. The proposed regulation recognizes the role that may be played by application counselors in helping individuals with the process through either the paper or online channels.

To effectively provide application assistance, counselors may have access to personal data, including tax data from the Internal Revenue Service that is subject to the confidentiality rules established under section 6103 of the Internal Revenue Code ("Code"). State Medicaid agencies will need to ensure that their application counselors, and any web infrastructure used by them, comply with applicable privacy and security rules associated with the disclosure and receipt of this data and other personal information as well as with the overall eligibility and enrollment process. Accordingly, we propose to add a new paragraph (c) to §435.908, as published in the Medicaid eligibility final rule, to establish standards for authorizing application counselors to assist individuals with the application and renewal process, including use of a dedicated web portal, as well as with managing their case between the eligibility determination and regularly scheduled renewals. We apply these provisions to state CHIP agencies through the addition of a cross-reference in §457.340, and propose similar regulations for certification of application counselors for the Exchange (see proposed §155.225 and section III.B.4 of this rulemaking). As recipients of federal financial participation, state Medicaid and CHIP agencies are reminded of their obligation to ensure that their programs, including their application counselor programs, provide equal access to individuals with limited English proficiency and

individuals with disabilities under applicable federal civil rights laws. As part of this obligation, state Medicaid and CHIP agencies should ensure the availability and provision of appropriate application assistance services, such as language assistance services and auxiliary aids and services, to meet the needs of these populations. Sometimes this obligation can be met by referral of individuals with limited English proficiency or individuals with disabilities to appropriate counselors participating in the agency's program. Many people applying for coverage also seek informal help from family, friends and local community-based organizations not identified on the application or authorized to communicate with the agency about the application. The proposed regulations do not pertain to such informal assistance.

We note that similar regulations for certified application counselors are proposed for the Exchange at §155.225. See discussion in section III.B.4. of the preamble. Application counselors would not need to go through two different certification processes. State Medicaid and CHIP agencies and the Exchange generally are charged under the §435.1200 and §457.348 of the Medicaid eligibility final rule and §155.345 of the Exchange final rule to work together to create a seamless and coordinated application and enrollment process for individuals applying for all insurance affordability programs. To achieve this in the case of certified application counselors, states could elect, for example, to create a single certification process for all insurance affordability programs, or each program could accept application counselors certified by another program.

(b) Authorized Representatives (§435.923 and §457.340)

Authorized representatives have historically helped ensure access to coverage for vulnerable individuals, such as seniors and those with disabilities. Although there is no formal limit on the number of individuals an authorized representative may assist – for example, a some institutions or an attorney may serve as such a representative for several clients – most authorized representatives serve in that capacity for one individual, for example for a parent or

incapacitated relative. Under current regulations at 42 CFR §435.907, retained in the Medicaid eligibility final rule, states must accept applications from authorized representatives acting on behalf of an applicant. In this rulemaking, we propose to add §435.923 establishing minimum requirements for the designation of authorized representatives. Proposed §435.923, which is applied to state CHIP agencies through the addition of a cross reference in proposed §457.340, is intended to ensure a consistent set of rules and standards for authorized representatives across all insurance affordability programs. We believe the proposed regulation is consistent with current policies and practice in most states today and therefore will not substantially affect state programs.

Specifically, we propose that, consistent with longstanding practice, applicants and beneficiaries may choose to designate an individual or organization to act on the applicant or beneficiary's behalf, or may have such a representative through operation of state law (for example, through a legal guardianship arrangement). The state may not restrict the ability of applicants and beneficiaries to have an authorized representative to only certain groups of applicants and beneficiaries.

Under proposed paragraph §435.923(a), applicants and beneficiaries who do not designate an authorized representative on their application must be able subsequently to do so, through both electronic and paper formats, as well as the other modalities described in §435.907(a). Legal documentation of authority to act on behalf of an applicant or beneficiary under state law, such as a court order establishing legal guardianship or a power of attorney may serve in the place of the applicant or beneficiary's designation. The option to submit such documentation is intended to enable applicants who do not have the capacity to provide a signature to authorize representation. Authorized representatives must agree, or be bound by requirements, to maintain the confidentiality of any information regarding the applicant or beneficiary provided by the agency. An applicant or beneficiary may authorize the

representative to act on his or her behalf in the activities set forth in proposed §435.923(b). In accordance with proposed paragraph (c), the applicant or beneficiary may change or withdraw his or her authorization at any time. The authorized representative also may withdraw his or her authorization of representation by notifying the agency. Under proposed §435.923(d), authorized representatives are responsible for fulfilling the responsibilities encompassed within the scope of the representation to the same extent as the individual he or she represents and must agree to maintain the confidentiality of information provided by the agency. Under proposed paragraph (e), providers and staff members or volunteers of other organizations serving as authorized representatives must agree to adhere to relevant confidentiality and conflict of interest protections, similar to the rules applied to eligibility workers at outstation locations set forth in §435.904(e) of the regulations. We note that, before data can be released to an authorized representative, the representative must meet the authentication and data security standards of the releasing entity. For example, information relating to an applicant's modified adjusted gross income from the Internal Revenue Service cannot be requested by or released to an authorized representative unless the representative meets the authentication and security standards established by the IRS under section 6103 of the Code. In the event that such authentication or security standards are not met, the agency would need to continue to process the individual's application to the extent possible without use of the data at issue.

We intend that the single streamlined application described in §435.907(b)(1) of the regulations will provide applicants the opportunity to designate an authorized representative and will collect the information necessary for such representative to enter into any associated agreements with the agency as part of the application process. States developing alternative applications under §435.907(b)(2) must collect the same information through their alternative applications or supplemental forms. Per proposed §435.923(f), the agency must accept electronic, including telephonically recorded, signatures authorizing representation as well as

handwritten signatures transmitted by facsimile or other electronic transmission. Designations of authorized representatives under the proposed regulation must be accepted through all of the modalities described in §435.907(a).

(c) Accessibility for Individuals who are Limited English Proficient (§435.905)

We are proposing to clarify regulations at §435.905(b) relating to the provision of information to persons who are limited English proficient in order to assure access to coverage for eligible individuals and to achieve alignment between the regulations governing Medicaid and CHIP with existing Exchange regulations at 45 CFR 155.205(c), issued in the Exchange eligibility final rule on March 27, 2012. We propose that providing language services means providing oral interpretation, written translations, and taglines (which are brief statements in a non-English language that inform individuals how to obtain information in their language). These language services will allow individuals who are limited English proficient to obtain information accessibly.

Longstanding §435.901 directs states to comply with the Civil Rights Act of 1964, as well as section 504 of the Rehabilitation Act of 1973, and all other relevant provisions of federal and state laws. Guidance published on August 8, 2003 (68 FR 47311) provides some parameters on language assistance services for persons who are limited English proficient, including oral interpretation and written translation services; this guidance is located at http://www.justice.gov/crt/about/cor/lep/hhsrevisedlepguidance.pdf. Guidance was subsequently released on the availability of enhanced federal matching funds available for translation and interpretation services in connection with improving outreach to, enrollment of, retention of, and use of services by children in Medicaid and CHIP. Federal Medicaid reimbursement is available for the provision of oral and written translation and interpretation services provided to Medicaid and CHIP beneficiaries as either administration or a medical-assistance related expenditure, at

varying matching rates, depending on the specific circumstances involved. (For more information, see our letter to State Health Officials (SHO) dated July 1, 2010, available at http://www.cms.gov/smdl/downloads/SHO10006.pdf and the CMCS Information Bulletin on translation services dated April 26, 2011, available at https://www.cms.gov/CMCSBulletins/downloads/Info-Bulletin-4-26-11.pdf.)

These proposed policies are consistent with sections 1413 and 2201 of the Affordable Care Act, sections 1902(a)(8), 1902(a)(19) and 1943(b)(1)(F) of the Act and §435.902 and §435.906 of the regulations. The proposed regulation at §435.905(b)(1) is designed to provide flexibility to states and to accommodate differences in populations and languages spoken in a state. As stated in our Medicaid eligibility final rule, after consultation with states and stakeholders, future sub-regulatory guidance will implement the regulatory standards proposed as well as coordinate our accessibility standards with those applied to other insurance affordability programs and other programs overseen by HHS, as appropriate. We also propose at §435.905(b)(3) to require the state to inform individuals of availability of these services, and how to access them. Proposed paragraph (b)(3) would apply to informing individuals of accessibility services described in §435.905(b)(2) of the Medicaid eligibility final rule (relating to services available to individuals with disabilities).

We note that under regulations adopted in the Medicaid eligibility final rule, application and renewal forms, websites and other electronic systems used to enroll individuals, and assistance provided to individuals must meet the accessibility standard in proposed §435.905(b) (see §§435.907(g), 435.916(g), 435.908, 435.1200(f) of the Medicaid eligibility final rule). Thus, to align with the current Exchange regulations issued in the Exchange Eligibility final rule at §155.205(c) and amending the accessibility standards in this proposed rule, we would also be modifying the standards for such forms, websites, and systems. In §§435.917(a)(2), 431.205(e), 431.206(d), and 435.956(g), we propose to apply these accessibility standards at §435.905(b) to

notices and appeals procedures. We note that the proposed modification of §431.206 is intended to provide that all notices and communications across our regulation at part 431, subpart E be accessible to people who are limited English proficient and with disabilities, including but not limited to references to notices in §§431.211, 431.224, and 431.245. We also propose to modify §457.110(a) and §457.340(e) to apply these accessibility standards to the CHIP program.

5. Medicaid Eligibility Requirements and Coverage Options Established by Other Federal Statutes

To facilitate development of the streamlined eligibility and enrollment system envisioned under the Affordable Care Act, we propose new or amended regulations to simplify several eligibility pathways established by other federal statutes, as follows:

(a) Coverage of Children and Families

(i) Mandatory Coverage of Children with Title IV-E Adoption Assistance, Foster Care, or Guardianship Care under Title IV-E (§435.145)

Section 471(a)(28) of title IV-E of the Act, as added by the Fostering Connections to Success and Increasing Adoptions Act of 2008 (Pub. L. 110-351), gives states and federally-recognized Tribes the option to provide kinship guardianship assistance payments on behalf of children placed with family members under certain conditions. Under section 473(b)(3)(C) of the Act, children on whose behalf such payments are made are mandatorily eligible for Medicaid to the same extent as children for whom federal foster care maintenance payments are made under title IV-E. Revisions to current regulations at §435.145 are proposed to implement these statutory provisions. Also, we are proposing to eliminate a duplicative rule at §435.115(e) for this group and to include in §435.145 certain provisions from §435.115(e) that are consistent with the statutory requirements, namely that an adoption assistance agreement is considered to be in effect regardless of whether adoption assistance is being provided or an interlocutory or

other judicial decree of adoption has been issued. These proposed changes clarify current policy and have no meaningful impact on state programs.

(ii) Extended Eligibility for Low-Income Families (§435.112, and §435.115)

(1) Families with Medicaid eligibility extended because of increased earnings or hours of employment (§435.112)

Sections 408(a)(11)(A), 1902(e)(1)(A), and 1931(c)(2) of the Act, implemented at existing §435.112, require a 4-month Medicaid extension for low-income families (including pregnant women without other children) eligible under section 1931 of the Act (because they met prior AFDC income eligibility requirements as modified at state option under section 1931(b)(2) of the Act) who otherwise would lose coverage due to a household member's increased earnings or a parent's increased working hours. This section applies if a Medicaid extension for at most 12 months under Transitional Medical Assistance (TMA) in accordance with section 1925 of the Act is not available (for example, because the federal authority for TMA has sunset). We propose revisions to §435.112 to align with the implementation of section 1931 of the Act in the Medicaid eligibility final rule for parents and other caretaker relatives at §435.110, pregnant women at §435.116, and children at §435.118.

(2) Families with Medicaid eligibility extended because of increased collection of spousal support (§435.115)

Sections 408(a)(11)(B) and 1931(c)(1) of the Act, implemented at existing §435.115(f) – (h), require a 4-month Medicaid extension for low-income families eligible under section 1931 of the Act who otherwise would lose coverage due to increased income from collection of child or spousal support under title IV-D of the Act. We propose to revise §435.115 to limit this requirement to spousal support because, while spousal support is counted as income under the MAGI-based methodologies described in §435.603, child support is not. Therefore, increased collection of child support will not affect Medicaid eligibility for parents or children once

MAGI-based methodologies take effect in 2014. Also, we propose to delete the obsolete paragraphs (a) through (d) of §435.115 relating to individuals "deemed to be receiving AFDC" and to delete paragraph (e) relating to eligibility for children receiving assistance under title IV-E of the Act as duplicative of §435.145.

(iii) Extended and Continuous Eligibility for Pregnant Women (§435.170) and Hospitalized Children (§435.172)

(1) Pregnant women eligible for extended or continuous eligibility (§435.170)

Section 435.170 of the existing regulations implements section 1902(e)(5) of the Act, requiring extended Medicaid eligibility through the last day of the month in which the 60-day post-partum period ends for women who were covered while pregnant. Section 1902(e)(6) of the Act requires states to provide "continuous eligibility" to pregnant women, once determined eligible under any eligibility group, regardless of changes in household income through the last day of the month in which the post-partum period ends. Pregnant women eligible for extended coverage under either provision are entitled to receive pregnancy-related services covered under the state plan in accordance with §435.116(d)(3) of the Medicaid eligibility final rule. We further clarify in a proposed new paragraph (d) of §435.170, consistent with section 1902(e)(6) of the Act, that extended or continuous eligibility does not apply to pregnant women only covered during a period of presumptive eligibility. These changes clarify current policy and have no meaningful impact on state programs.

(2) Continuous eligibility for hospitalized children (§435.172)

Section 1902(e)(7) of the Act requires that infants and children under age 19 eligible under sections 1902(a)(10)(A)(i)(III), (IV), (VI), and (VII) and (ii)(IX) of the Act remain eligible for Medicaid until the end of a Medicaid-covered inpatient stay, if they otherwise would lose eligibility because of attaining the maximum age for coverage under the applicable section of the Act. We propose to add a new section §435.172 implementing this requirement for children

eligible under §435.118 of the Medicaid eligibility final rule. This section clarifies current policy and has no meaningful impact on state programs.

(iv) Optional Eligibility Groups and Coverage Options

(1) Optional Eligibility for Parents and Other Caretaker Relatives (§435.220)

Optional eligibility for pregnant women and parents or other caretaker relatives under section 1902(a)(10)(A)(ii)(I) of the Act is currently implemented at §435.210. Optional eligibility for pregnant women, effective January 1, 2014, is implemented at §435.116 of the Medicaid eligibility final rule. Optional eligibility for most parents and other caretaker relatives now covered under §435.210 (those with MAGI-based income at or below 133 percent FPL) will be subsumed under the adult group at §435.119, if they are not elderly and not Medicare eligible. Eligibility for parents and other caretaker relatives with MAGI-based income above the limits for mandatory coverage under §435.110 and §435.119 will remain an option under §435.220 as proposed in this rule. The eligibility group defined in the existing regulations at §435.220 (for individuals who would meet the income and resource requirements under AFDC if child care costs were paid from earnings) will be rendered obsolete with the prohibition against income disregards under MAGI-based methods per §435.603(g).

Consistent with our efforts to streamline and simplify eligibility in the Medicaid eligibility final rule, we propose in this rulemaking to delete pregnant women and parents or other caretaker relatives from the scope of the current regulation at §435.210 and to replace the obsolete provision currently provided for in §435.220 with optional eligibility of parents and other caretaker relatives based on MAGI. A state may cover parents and other caretaker relatives under this section, including individuals who are elderly or Medicare eligible, if their household income does not exceed the income standard established by the state for this group. The income standard may not exceed the higher of the state's AFDC payment standard in effect as of July 16, 1996 or the state's highest effective income level for optionally eligible parents

and other caretaker relatives under the state plan or 1115 demonstration as of March 23, 2010 or December 31, 2013, if higher, converted to a MAGI-equivalent standard per section 1902(e)(14)(A) and (E) of the Act, in accordance with guidance as issued by the Secretary. States will also have the option to provide Medicaid to parents and other caretaker relatives, along with other individuals under age 65, with income above 133 percent FPL under the new optional eligibility group codified at §435.218 of the Medicaid eligibility final rule.

(2) Optional Coverage for Reasonable Classifications of Individuals under Age 21 (§435.222)

The existing regulation at §435.222 implements sections 1902(a)(10)(A)(ii)(I) and (IV) of the Act to give states the option to cover all individuals under age 21 (or, at state option, under age 20, 19, or 18) or reasonable classifications of such individuals, who either meet the state's AFDC income and resource requirements or would meet them if not institutionalized. We propose revisions to §435.222 to reflect the need for states to convert their current AFDC-based net income standard to an equivalent MAGI-based standard, unless the state currently disregards all income for a reasonable classification under this group. The income standard, if any, established by the state for all individuals or each reasonable classification under this group which may not exceed the higher of the state's AFDC payment standard in effect as of July 16, 1996 or the state's highest effective income level for the group or reasonable classification under the state plan or 1115 demonstration as of March 23, 2010 or December 31, 2013, if higher, converted to a MAGI-equivalent standard.

(3) Optional Eligibility for Individuals Needing Treatment for Breast or Cervical Cancer (§435.213)

We propose to add a new §435.213 to codify section 1902(a)(10)(A)(ii)(XVIII) of the Act, consistent with existing guidance, which provides states with the option to cover individuals needing treatment for breast or cervical cancer. The eligibility criteria for this optional eligibility group are set forth at section 1902(aa) of the Act. Guidance on this group was provided in a

state Health Official letter (SHO) dated January 4, 2001, http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/sho010401.pdf. Inasmuch as the proposed regulation codifies this guidance, which remains effective, this section should not have any meaningful impact on state programs.

This optional eligibility group covers individuals under age 65 who are not eligible and enrolled for mandatory coverage under the Medicaid state plan; do not otherwise have creditable coverage for treatment of their breast or cervical cancer; and have been screened as needing treatment for breast or cervical cancer under a state's Centers for Disease Control and Prevention (CDC) breast and cervical cancer early detection program (BCCEDP). This may include any men screened under the state's screening program for breast cancer. The state entity administering the BCCEDP, not the state Medicaid agency, determines who is considered to have been "screened under the program" and establishes the scope of screening provided, regardless of funding source, so that if the state entity considers a man to have been screened under the BCCEDP program, a state electing to cover this Medicaid eligibility must cover such man under this group.

(4) Optional Eligibility for Independent Foster Care Adolescents (§435.226)

We propose to add a new §435.226 to codify section 1902(a)(10)(A)(ii)(XVII) of the Act, which provides states with the option to cover "independent foster care adolescents" as described at section 1905(w) of the Act. This existing optional eligibility group covers individuals who are under age 21 (or, at state option, under age 20 or 19) and were in foster care under the responsibility of a state or Tribe on the individual's 18th birthday. As with reasonable classifications of individuals under §435.222, states which covered such group under the Medicaid state plan or an 1115 demonstration as of March 23, 2010 or December 31, 2013 will need to convert the effective income level, if any, to a MAGI-based standard. The income

standard may not exceed the higher of the state's AFDC payment standard in effect as of July 16, 1996 or the state's highest effective income level for this population under the state plan or 1115 demonstration as of March 23, 2010 or December 31, 2013, if higher, converted to a MAGI-equivalent standard. Many individuals now covered under this optional group will be eligible for coverage as of 2014 under either the new group for former foster care children at the proposed §435.150 or the adult group at §435.119, both of which are mandatory eligibility groups under the statute. Unlike the group at §435.150, this optional group at §435.226 does not require enrollment in Medicaid upon attaining age 18 in foster care, but coverage in this group ends upon attaining age 21 rather than age 26.

(5) Optional Eligibility for individuals under Age 21 Who Are under State Adoption Assistance Agreements (§435.227)

We propose to amend §435.227 for children with a state adoption assistance agreement in effect (other than an agreement under title IV-E of the Act) to reflect the need for states to convert the current AFDC-based net income standard, if any, to an equivalent MAGI-based standard. If the state covered this group under the Medicaid state plan or an 1115 demonstration as of March 23, 2010 or December 31, 2013 with no income test or MAGI-based effective income level, converted to a MAGI-equivalent standard, exceeding the state's income standards for §435.118 and §435.119, that policy may remain in effect. Otherwise, consistent with the existing regulation at §435.227(a)(3)(i) and retained at proposed §435.227(b)(3)(i) of this rulemaking, an individual must have been eligible under the Medicaid state plan prior to the adoption agreement being entered into. We request comments on our proposal to delete the alternative eligibility requirement in existing regulations at §435.227(a)(3)(ii) that the individual would have been eligible if the state's title IV-E foster care financial eligibility standards and methodologies were used, because the Medicaid eligibility requirements at §435.118 of the Medicaid eligibility final rule are more expansive. Also, we propose language at

§435.227(b)(2), revising the language in existing regulations at §435.227(a)(2), to clarify that it is the state agency which entered into the adoption agreement with the adoptive parents, which is not necessarily the state determining the child's Medicaid eligibility, that determines whether those eligibility requirements are met.

(6) Optional Targeted Low-Income Children (§435.229)

We propose to amend §435.229 for optional targeted low-income children, as defined at §435.4, for whom states may claim enhanced match under section 1905(b) and title XXI of the Act, in order to reflect the need for states to convert the current AFDC-based net income standard to an equivalent MAGI-based standard. A state's income standard may not exceed the higher of 200 percent FPL; an FPL percentage which exceeds the state's Medicaid applicable income level, defined at §457.10, by no more than 50 percentage points; or the highest effective income level for this group in effect under the Medicaid state plan or an 1115 demonstration as of March 23, 2010 or December 31, 2013, if higher, converted to a MAGI-equivalent standard.

(7) Optional Continuous Eligibility for Children (§435.926 and §457.342)

We propose to add a new §435.926 codifying section 1902(e)(12) of the Act, which provides states with the option to provide up to 12 months of continuous eligibility for children under age 19, or a younger age selected by the state, once determined eligible for Medicaid, regardless of changes in income or most other circumstances which otherwise would render the child ineligible for Medicaid. These proposed standards codify and clarify past guidance on the continuous eligibility options and have no meaningful impact on state programs. Under the option, continuous eligibility is provided to all children younger than the state's specified age who are covered under subpart B or C of this part, but not those covered as medically needy under subpart D, those eligible only for emergency medical services for non-citizens, or those eligible during a period of presumptive eligibility. Thus, consistent with the statute, states electing the option for continuous eligibility under proposed §435.926 must provide such

coverage to children eligible under §435.118 as well as all children covered under any other mandatory or optional group covered by the state, including children eligible based on receipt of SSI, disability, institutionalization, or enrollment in a section 1915(c) home and community-based services waiver. Also proposed is §457.342 for continuous eligibility of children under a state's separate CHIP.

Under proposed §435.926(c), the state would specify in its state plan the length of a continuous eligibility period, not to exceed 12 months. A continuous eligibility period begins on the effective date of the individual's most recent determination or renewal of eligibility and ends at the end of the length of the continuous eligibility period specified by the state. Under proposed paragraph (d), children remain eligible during a continuous eligibility period regardless of any change in circumstances except attaining the maximum age elected by the state for this option, death, voluntary disenrollment, change in state residence, state error in the eligibility determination, or fraud, abuse, or perjury attributed to the child or the child's representative.

(8) Optional Tuberculosis Eligibility Group (§435.215)

We propose to add a new §435.215 for optional tuberculosis (TB)-infected individuals to codify section 1902(a)(10)(A)(ii)(XII) and (z)(1) of the Act. These provisions provide states with the option to provide Medicaid to TB-infected individuals who are not eligible for Medicaid under subpart B of this part (relating to Mandatory Coverage of the Categorically Needy) and meet certain income and resource requirements. The medical assistance available to individuals eligible in this category is limited to TB-related services, which are defined in section 1902(z) of the Act as: prescribed drugs; physicians' services and services described in section 1905(a)(2); laboratory and X-ray services (including services to confirm the presence of infection); clinic services and federally-qualified health center services; case management services (as defined in section 1915(g)(2)); and services (other than room and board) designed to encourage completion of regimens of prescribed drugs by outpatients, including services to observe directly the intake

of prescribed drugs.

The statute limits eligibility in this group to TB-infected individuals whose incomes and resources do not exceed the maximum amount a disabled individual described in subpart B of this part may have and obtain medical assistance under the state plan. The income and resource tests are both based on SSI standards and methodologies, and these rules remain in effect until January 1, 2014.

However, except as provided in section 1902(e)(14)(D) of the Act, section 1902(e)(14)(A) of the Act provides that notwithstanding any other provision of title XIX, financial eligibility for Medicaid for all individuals effective January 1, 2014, will be based on the MAGI-based methodologies set forth in section 1902(e)(14) of the Act. Because TB-infected individuals who qualify for Medicaid on that basis do not meet any of the exceptions from the MAGI-based income rules listed in section 1902(e)(14)(D) of the Act, implemented in §435.603(j) of the Medicaid eligibility final rule, we propose that, effective January 1, 2014, income eligibility for this group must be determined in accordance with the MAGI rules in §435.603. States electing to cover this eligibility group need to establish an income standard in their state plan. Under proposed §435.215(b)(3), the income standard must not exceed the higher of the maximum income standard applicable to disabled individuals for mandatory coverage under subpart B of part 435 of the regulations, or the effective income level for coverage of TB-infected individuals under the state plan in effect as of March 23, 2010 or December 31, 2013, if higher, converted, at state option, to a MAGI-equivalent standard in accordance with guidance issued by the Secretary under section 1902(e)(14)(A) and (E) of the Act. Per §435.603(g) of the Medicaid eligibility final rule, there will be no resource test for eligibility under this section effective January 1, 2014.

We considered an interpretation of the statute under which, because section 1902(z) of the Act currently provides for application of the financial standards and methods generally used

to determine eligibility based on disability, individuals infected with TB and eligible for coverage on such basis would be considered to "qualify for medical assistance … on the basis of being blind or disabled" for purposes of the exception from application of MAGI methodologies set forth in section 1902(e)(14)(D)(i)(III) of the Act. Under this interpretation, application of the income standards and methodologies applied to coverage of disabled individuals, as provided in with section 1902(z) of Act, would continue to be applied to coverage under this eligibility group after January 1, 2014. We solicit comments on this alternative interpretation.

b. Presumptive Eligibility

(i) Proposed amendments to Medicaid regulations for presumptive eligibility

We propose to revise Medicaid regulations for children's presumptive eligibility and to add regulations for presumptive eligibility for pregnant women and individuals needing treatment for breast or cervical cancer as well as for the six new options for Medicaid presumptive eligibility provided by the Affordable Care Act. The new options become available on January 1, 2014, except that presumptive eligibility for the family planning option became available on March 23, 2010.

(1) FFP for administration (§435.1001)

We propose to revise paragraph (a)(2) of §435.1001 to clarify, consistent with current policy, that federal financial participation (FFP) is available for the necessary administrative costs a state incurs in administering all types of presumptive eligibility, not just presumptive eligibility for children as now specified in this section.

(2) FFP for services (§435.1002)

We propose to revise paragraph (c) of §435.1002 to clarify that FFP is available for services covered for all individuals determined presumptively eligible in accordance with the statute and implementing regulations, rather than just for children as now specified in this section.

(3) Basis for presumptive eligibility (§435.1100)

We propose to revise §435.1100 to address the statutory basis of presumptive eligibility under sections 1920, 1920A, 1920B, 1920C, and 1902(a)(47)(B) of the Act for children, pregnant women, and other individuals under subpart L, including the six new options provided by the Affordable Care Act.

(4) Definitions (§435.1101)

We propose to revise §435.1101 to replace the definition of "application form" with "application" to reflect current practices and to clarify that the definition of "qualified entity" includes a health facility operated by the Indian Health Service, a Tribe or Tribal organization, or an Urban Indian Organization.

(5) Presumptive eligibility for children (§435.1102)

We propose to revise existing regulations at §435.1102, under which states may select qualified entities to determine presumptive eligibility for children under age 19 or a younger age selected by the state. A qualified entity determines, based on preliminary information, that the child's gross income (or at state option, MAGI household income as defined at §435.603 or a reasonable estimate using simplified methods prescribed by the state) meets the income requirements at §435.118(c) of the Medicaid eligibility final rule. The proposed changes, which are consistent with current policy and practice in states, are needed to align with the adoption of MAGI-based methodologies in 2014 and to ensure consistency between the policies governing the existing and new presumptive eligibility options.

We propose to amend §435.1102(b) to clarify that a qualified entity may not delegate to another entity its authority to determine presumptive eligibility and that the state must establish oversight mechanisms to ensure the integrity of presumptive eligibility determinations. We propose at §435.1102(d) that a state may require, as a condition of presumptive eligibility, that an individual, or another person who attests to having reasonable basis to know the status of the

individual seeking a presumptive eligibility determination, attests that the individual is a citizen or a national of the United States or is in satisfactory immigration status. We seek comment on whether this should be a state option or a requirement. A state may also require similar attestation that the individual is a state resident. Because the statute requires qualified entities to determine presumptive eligibility "on the basis of preliminary information," under the proposed regulations states would be prohibited from requiring verification of the conditions for presumptive eligibility and from imposing additional conditions for presumptive eligibility. Proposed paragraph (e) clarifies that a presumptive eligibility determination by a qualified entity is not subject to fair hearing rights under subpart E of 42 CFR part 431.

(6) Presumptive eligibility for other individuals (§435.1103)

We propose to add §435.1103 to implement the presumptive eligibility for other populations permitted under sections 1920, 1920A, 1920B, and 1920C of the Act. At paragraph (a), we propose, consistent with section 1920 of the Act and current policy, that a state may elect to provide presumptive eligibility for pregnant women in the same manner as described for children at the proposed §435.1101 and §435.1102, except that pregnant women are only covered for ambulatory prenatal care during a presumptive eligibility period. We also propose that pregnant women are limited to one presumptive eligibility period per pregnancy. As prescribed in the statute, if the state has elected to provide presumptive eligibility for children or pregnant women, the state may also elect to provide presumptive eligibility for the additional populations provided for in the Affordable Care Act – that is, -- parents and other caretaker relatives (described in §435.110, adults described in §435.119, and individuals under age 65 described in §435.218 of the Medicaid eligibility final rule, as well as former foster care children described in §435.150 of this proposed rulemaking. We propose at paragraph (c) that a state may cover presumptive eligibility for individuals needing treatment for breast or cervical cancer as described at proposed §435.213 of this rulemaking; and at paragraph (d) that a state may

provide family planning services on a presumptive eligibility basis for individuals who may be eligible for such services under proposed §435.214 of this rulemaking.

(7) Presumptive eligibility determined by hospitals (§435.1110)

We propose to add §435.1110 for hospitals electing to determine presumptive eligibility. The Affordable Care Act added section 1902(a)(47)(B) of the Act to give hospitals the option (not at state option like for the other types of presumptive eligibility), as of January 1, 2014, to determine presumptive eligibility for Medicaid. The Act provides hospitals participating in Medicaid with this option whether or not the state has elected to permit qualified entities to make presumptive eligibility determinations under other sections of the statute.

At paragraph (a) of §435.1110, we propose that a qualified hospital may elect to make presumptive eligibility determinations, on the basis of preliminary information and according to policies and procedures established by the state Medicaid agency. Proposed paragraph (b) establishes the basic criteria which a hospital must meet to be a qualified hospital authorized to make presumptive eligibility determinations, including that the hospital (1) participate as a Medicaid provider, (2) notify the agency of its decision to make presumptive eligibility determinations, (3) agree to make determinations consistent with state policies and procedures, (4) at state option, assist individuals in completing and submitting the full application and in understanding any documentation requirements, and (5) not be disqualified by the agency under proposed paragraph (d) (discussed below).

At paragraph (c) of this section, we specify that a state Medicaid agency may limit presumptive eligibility determinations by qualified hospitals to the types of presumptive eligibility that the agency may elect to cover, as described at proposed §435.1101 through §435.1103. In addition, qualified hospitals may be permitted by the agency to determine presumptive eligibility on other bases under the state plan or 1115 demonstration (for example, based on disability).

We propose at paragraph (d) that the agency may establish standards for qualified hospitals making presumptive eligibility determinations related to the proportion of individuals determined presumptively eligible for Medicaid by the hospital that submit a regular application before the end of the presumptive eligibility period and/or are determined eligible for Medicaid based on such application. We request comments on whether this should be a federal requirement, a state option, or neither, and what such reasonable standards would be. The agency must take action as necessary if a hospital does not meet the standards established by the agency or is not making determinations in accordance with applicable state policies and procedures.

(ii) Proposed Amendments to CHIP Regulations for Presumptive Eligibility (§457.355)

In order to align the regulations governing presumptive eligibility for children under CHIP with Medicaid, we revise current regulations at §457.355 to incorporate by cross reference the terms of §435.1101 and §435.1102 (relating to presumptive eligibility for children in Medicaid) into our CHIP regulations. In addition, prior to passage of CHIPRA, states were permitted to claim enhanced federal matching funds under their CHIP title XXI allotment for coverage of children during a Medicaid presumptive eligibility period; this authority is implemented in the current regulations at §457.355 and §457.616(a)(3). Section 113(a) of CHIPRA, however, amended section 2105(a)(1) of the Act to eliminate this authority, so that, effective April 1, 2009, states must claim their regular federal financial participation under title XIX for services provided to children during a Medicaid presumptive eligibility period. This change is implemented through the proposed revisions to §457.355 and by deleting §457.616(a)(3).

2. Medically Needy (§§ 435.301, 435.310, 435.831)

Under section 1902(e)(14)(D)(i)(IV) to the Act, as added by section 2002(a) of the Affordable Care Act and codified at §435.603(j)(6), the determination of eligibility for medically

needy individuals is excepted from application of MAGI-based financial methodologies set forth at §435.603. Under section 1902(a)(10)(C)(i)(III) of the Act, financial eligibility under a medically-needy group for children, pregnant women, parents, and other caretaker relatives "shall be no more restrictive than the methodology that would be employed under the appropriate state plan described in [section 1902(a)(10)(A)(i) of the Act] to which such group is most closely categorically related." Currently, for pregnant women, parents, children, and other caretaker relatives the methods of the former AFDC program are applied. For aged, blind, and disabled individuals, section 1902(a)(10)(C)(i)(III) of the Act requires the use of a methodology that is no more restrictive than the methods applied under the SSI program.

As the former AFDC program has now been eliminated, there is no state plan described in section 1902(a)(10)(A)(i) of the Act that is "most closely categorically related" to pregnant women, parents, children, and other caretaker relatives. In addition, retaining the AFDC methodologies for the purpose of determining countable income for medically needy coverage could be burdensome for states and consumers, and could undermine the simple streamlined eligibility process required under section 1943 of the Act and section 1413 of the Affordable Care Act, as well as the requirements under section 1902(a)(19) of the Act to administer the program in a simple and efficient manner and in the best interest of beneficiaries. Therefore, we are proposing to revise §435.831 to provide states with flexibility to apply, at state option, either AFDC-based methods or MAGI-based methods for determining income eligibility for medically needy children, pregnant woman, and parents and other caretaker relatives – individuals whose financial eligibility generally will be determined using MAGI-based methods. Although section 1902(e)(14)(A) and 1902(e)(14)(D)(i)(IV) of the Act indicates that states cannot be <u>required</u> to apply MAGI-based methods in determining financial eligibility for medically needy individuals, we believe that this does not preclude us from permitting states to apply MAGI-based income methodologies in determining medically needy eligibility for these populations.

However, we also recognize that section 1902(a)(17)(D) of the Act prohibits state plans from taking into account the "financial responsibility of any individual for any applicant or recipient of assistance under the plan unless such applicant or recipient . . . is such individual's spouse or such individual's child who is under age 21, . . . or is blind or disabled."

Thus, states may use a MAGI-based methodology in determining household income using MAGI-based methods, but in doing so, must ensure that there is no deeming of income or attribution of financial responsibility that would conflict with the requirements of section 1902(a)(17)(D). States could, for example, apply the methodology set forth in §435.603 of the Medicaid eligibility final rule, and, in cases involving impermissible deeming, subtract the income of the individual whose income may not be counted under §1902(a)(17)(D). States may also, but would not be required to, remove such individual from the household size. We note also that section 1902(r)(2) of the Act and §435.601(d) of the current regulations provide states with an option to adopt other reasonable methodologies, provided that such methods are less restrictive than the SSI, AFDC or the MAGI-based methods permitted under this proposed rule.

Furthermore, in order to meet the maintenance of effort requirements (MOE) in section 1902(gg) of the Act, states would have to ensure that the adoption of MAGI methodologies is no more restrictive than the methodology currently used by the state in determining the eligibility of children as medically needy until the MOE expires in 2019. For purposes of this section, states may replace current disregards applied to medically needy individuals, some of which may benefit only part of its medically needy population (such as a disregard for amounts for child care), with a single block-of-income disregard made available to all medically needy individuals such that in the aggregate the MOE is satisfied.

In addition, we are removing the reference to "family" in §435.831(c) to be consistent with the implementation of eligibility for low-income families under section 1931 of the Act in the final Eligibility Rule. Since eligibility under section 1931 of the Act, like all other bases of

eligibility, will be determined on an individual basis, parents and other caretaker relatives will be evaluated for medically needy eligibility as individuals, as currently is the case of pregnant women and children.

d. Optional Eligibility of Lawfully-residing Non-citizen Children and Pregnant Women (§§ 435.4, 435.406, 457.320)

Section 214 of CHIPRA amended section 1903(v)(4) of the Act to permit states to provide Medicaid coverage to children, pregnant women, or both who are lawfully residing in the United States, and otherwise eligible for Medicaid. We are proposing to amend §435.406 by revising paragraph (b) to implement this option. Section 214 of CHIPRA also amended section 2107 of the Act similarly to allow states to cover such lawfully residing children and pregnant women under CHIP. We also propose at 45 CFR 155.20 to align the Exchange definition of "lawfully present" with the Medicaid/CHIP definition in §435.4. Individuals who meet this definition could be eligible for enrollment in a QHP through the Exchange.

On July 1, 2010, we issued a State Health Official (SHO) letter providing guidance implementing section 214 of CHIPRA. In the SHO, we interpreted "lawfully residing" to mean individuals who are lawfully present in the United States and who are residents of the state in which they are applying under the state's Medicaid or CHIP residency rules. Because state residency is a separate eligibility criteria which must be established independent of an individual's immigration status as a lawfully present non-citizen, we are proposing to use the term "lawfully present" in §435.406(b), without need to include a definition of "lawfully residing" in these proposed regulations. Eligibility for Medicaid under §435.406(b) cannot be approved for an individual who is lawfully present in the United States, if the individual is not also a resident of the state under the state's residency rules. For example, a nonimmigrant visitor for business or pleasure may be lawfully present under immigration regulations, but not meet

Medicaid or CHIP residency requirements, and therefore will not be able to qualify for Medicaid or CHIP based on residency.

Current paragraph (b) of §435.406 is re-designated and revised at proposed paragraph (c) and we propose to add a new paragraph (b). We also propose new definitions of "lawfully present," "non-citizen," "qualified non-citizen" at §435.4. Policies consistent with our already-issued July 1, 2010 SHO letter, are only briefly discussed and we refer readers to the letter for a more in-depth discussion (at http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SHO10006.pdf). Explained in more depth herein are several modest proposed changes in policy as compared to the SHO.

Consistent with the SHO, under proposed §435.406(b)(1), if a state elects the CHIPRA 214 option for pregnant women and/or children, then it must elect the option for all children and/or pregnant women who are lawfully present, as defined in §435.4; in other words, the state cannot choose among "lawfully present" children or pregnant women and offer Medicaid to some, but not others. We propose in §435.406(c) consistent with our current policy, that if a state elects to cover lawfully present children and/or pregnant women under §435.406(b), such individuals may be eligible for any Medicaid eligibility group covered under the state plan for which he or she meets all other eligibility requirements.

In accordance with section 1903(v)(4)(A) and (B) of the Act, proposed §435.406(b)(2) provides that various limitations otherwise applicable to non-citizen eligibility do not apply to lawfully present non-citizens covered pursuant to a state's election of the option provided at paragraph (b)(1). The restrictions that do not apply to individuals under 21 or pregnant women covered under this option include, the 5-year waiting period described in section 403 of PRWORA, 8 U.S.C. 1613; the restriction relating to the limitation on payment services for individuals who are not qualified non-citizens under section 401(a) of PRWORA, 8 U.S.C. 1611(a); deeming of sponsor income under section 421 of PRWORA, 8 U.S.C. 1631; and the

state option to require Lawful Permanent Residents to be credited with 40 qualifying quarters of work or limitation of coverage to seven years, permitted under section 402(b) of PRWORA, 8 U.S.C. 1612(b). We propose a new paragraph (c) of §435.406, revising and redesignating current paragraph (b) clarifying which non-citizens would be eligible to receive coverage of services of an emergency medical condition including in states that elect to cover children and pregnant women under the option in paragraph (b)(1).

The definition of "lawfully present" proposed at §435.4 is substantially the same as that contained in our July 1, 2010 guidance and at 45 CFR 152.2 (the current definition used for Exchange eligibility) with some minor modifications to further simplify the rules as well as ensure alignment with the eligibility of lawfully present non-citizens for advance payment of the premium tax credit, cost-sharing reductions, and enrollment in a QHP through the Exchange. As these modifications do not substantially affect eligibility, we do not anticipate an impact on state costs. As explained in the SHO, our policy is based on the definition provided in Department of Homeland Security (DHS) regulations at 8 CFR 1.3, used for purposes of Social Security benefits, with some modification appropriate to the Medicaid and CHIP programs.

We propose the following limited differences in the definition of "lawfully present" in this proposed rulemaking as compared to our July 1, 2010 SHO.

We propose inclusion of victims of trafficking, at paragraph (9) whose eligibility for Medicaid is mandatory under federal law under section 107 of the Victims of Trafficking and Violence Protection Act of 2000 (Pub. L. 106-386) as amended 22 USC 7105). Inclusion of victims of trafficking in the definition of "lawfully present" is needed to ensure alignment of current Medicaid rules with eligibility for advance payment of the premium tax credit, cost-sharing reductions, and enrollment through the Exchange. We note that these individuals are required to be covered in Medicaid, through the Victims of Trafficking Act. Thus, regardless of

whether a state elects to cover lawfully residing children or pregnant women under the option codified at proposed §435.406(b), coverage of these individuals is required if they meet all other eligibility requirements.

In the definition of lawfully present proposed at §435.4, with respect to non-citizens with a valid non-immigrant status, we propose in paragraph (2) to include all non-immigrants who have a valid status, rather than limiting inclusion to such individuals who also have not violated the terms of their status, as specified in the SHO. This allows coverage to non-immigrants who have valid and unexpired status, without requiring state Medicaid agencies to understand all the terms of such status, and to determine whether any terms have been violated. This, in turn, will enable agencies to verify this non-citizen status through a data match with DHS through the federal data services hub (using that Department's Systematic Alien Verification for Entitlements (SAVE) system), for virtually all non-immigrant applicants or beneficiaries without further investigation.

With respect to individuals granted an employment authorization document (EAD) under 8 CFR §274a.12(c), we propose in the definition of lawfully present at paragraph (4)(iii) to include most non-citizens granted such document, instead of limiting inclusion only to specified groups of individuals granted an EAD, as was done in the SHO, thereby enabling verification of satisfactory immigration status through SAVE, which typically can verify a grant of EAD in three to five seconds. We note that this proposed modification should not result in an expansion of eligibility, but only a simplification of verification processes for these individuals. It is our understanding that all individuals granted an EAD under §274a.12(c), are already considered lawfully present under another category under our SHO, with the exception provided in the proposed regulation at paragraph (10).

We propose in the definition of lawfully present at §435.4 to add two additional categories of non-citizens not included in the definition of "lawfully present" in the SHO. First,

we propose in §435.4 at paragraph (4)(vii) inclusion of individuals who have been granted an administrative stay of removal by DHS. We seek comments on whether we should include individuals granted an administrative stay by U.S. Department of Justice. Such stays provide non-citizens with permission to remain living in the United States. We considered also adding individuals who have been granted stays by a court (as opposed to administratively issued by DHS). We understand some court stays are effective without any consideration of the filing, merely by the individual filing for such a stay. We seek comments on this provision and alternative ways to address those for whom a court has considered an individual's situation and granted a stay.

Second, at paragraph (10) of the definition, we propose to add an exception to the lawfully present definition to specify that individuals with deferred action under the Deferred Action for Childhood Arrivals (DACA) process shall not be eligible for Medicaid and CHIP under the CHIPRA state option with respect to any of the categories (1) through (9),in accordance with and based on the rationales included in the interpretative guidance set forth in a SHO letter, #12-002 issued August 28, 2012, available at www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-12-002.pdf and in the interim final rule with request for comments to the Pre-Existing Condition Insurance Plan (PCIP) Program (77 FR 52614, Aug. 30, 2012). We propose that the "lawfully present" definition in the Exchange rules would also incorporate this exception.

We note that we propose to remove the language contained in our SHO specifically related to individuals who are lawfully present in the Commonwealth of the Northern Mariana Islands (CNMI) under 48 U.S.C. §1806(e) from our definition of lawfully present at §435.4. We understand this statutory provision expired on November 28, 2011, which was two years after the transition program to extend U.S. immigration laws to the CNMI's immigration system began. We believe that most of these individuals will continue to be covered under our

definition of lawfully present at §435.4 in other categories, including as non-immigrants or parolees.

We solicit comments on the definition of lawfully present in this proposed regulation. Codification of other statutes relating to categories of non-citizens who are eligible for Medicaid (including under title IV of PRWORA and subsequent federal legislation) that are not reflected in our current regulations are not included in this proposed rulemaking.

We also propose to amend §457.320(c) to implement section 2107(e)(1) of the Act, to permit a separate CHIP program to cover "lawfully residing" children or pregnant women otherwise eligible for CHIP. We propose to align the terminology and the option to provide coverage for "lawfully present" children and pregnant women in CHIP under §457.320(c) with policy for Medicaid in proposed §435.406(b). The same definition of "lawfully present" proposed for Medicaid also is proposed for CHIP. Consistent with the statute, states may not choose to cover these new groups only in CHIP, without also having extended the option to Medicaid. As section 1903(v)(4)(A) of the Act merely lifts restrictions for lawfully residing, otherwise eligible individuals, a state must have coverage that would otherwise include the individual. Thus, lawfully present pregnant women could be covered under CHIP only if the CHIP program has elected to cover pregnant women generally, either under a waiver or demonstration or under the option provided under section 2112 of the Act to cover pregnant women under its CHIP state plan.

e. Deemed Newborn Eligibility (§435.117 and §457.360)

(i). Medicaid Deemed Newborn Eligibility (§435.117)

Section 1902(e)(4) of the Act and existing §435.117 require that babies born to mothers covered under the Medicaid state plan for benefits on the date of birth, including during a period of retroactive eligibility, be automatically deemed eligible for Medicaid for one year from birth. The provision is intended to ensure coverage of the newborn without any gaps; no application is

required. In accordance with section 1903(x)(5) of the Act, as added by section 211(b)(3)(A)(ii) of CHIPRA and consistent with previous guidance, we clarify at proposed paragraph (b)(1)(i) of §435.117 that a child born to a mother covered by Medicaid for labor and delivery as an emergency medical service pursuant to section 1903(v)(3) of the Act shall be deemed eligible for Medicaid during the child's first year of life.

Section 113(b)(1) of CHIPRA amended section 1902(e)(4) of the Act effective April 1, 2009 to eliminate the previous statutory requirement that eligibility under this section continue only so long as the baby was a member of the mother's household and the mother either remained eligible for Medicaid or would remain eligible if still pregnant. We propose revisions to §435.117(b) to implement this change in the statute. Previous guidance was provided in SHO letter #09-009 dated August 31, 2009, http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SHO083109b.pdf.

Section 111 of CHIPRA added a new section 2112 to title XXI of the Act, giving states the option to cover targeted low-income pregnant women under a separate CHIP state plan. Section 2112(e) of the Act requires that babies born to such pregnant women covered under the CHIP state plan for benefits for the date of birth are deemed to have applied and been determined eligible for Medicaid or CHIP, as appropriate, and remain eligible for one year. At §435.117(b)(1)(ii), we interpret this to mean that babies born to pregnant women on CHIP with household income at or below the applicable Medicaid income standard for infants under §435.118 of the Medicaid eligibility final rule must be automatically enrolled in Medicaid, and those born to pregnant women with income above the applicable Medicaid income standard must be automatically enrolled in CHIP.

To promote simplicity of administration and the best interest of beneficiaries, consistent with section 1902(a)(19) of the Act, we also propose at §435.117(b)(1)(iii) that states be provided with the option to treat as deemed newborns in Medicaid the babies born to mothers

covered as a child under a separate CHIP for benefits for the date of birth. We solicit comments on whether states should have the option to extend automatic Medicaid enrollment to the extent that the state determines that, under normal circumstances, such babies would be likely to meet requirements for Medicaid eligibility: (1) to all babies born to mothers covered as a targeted low-income child under a separate CHIP, (2) only to such babies if the state has elected the option to cover targeted low income pregnant women under its CHIP state plan, even if the mother does not qualify as a targeted low-income pregnant woman, or (3) to no such babies born to mothers covered as a targeted low-income child under a separate CHIP who do not qualify as a targeted low-income pregnant woman. Also consistent with section 1902(a)(19) of the Act, we propose at §435.117(b)(1)(iv) that states be provided with the option to treat as deemed newborns in Medicaid the babies born to mothers covered under a Medicaid or CHIP demonstration under section 1115 of the Act, unless the demonstration's special terms and conditions (STCs) specifically address this issue.

We also propose a new paragraph (c) to give states the option of recognizing the deemed newborn status from another state for purposes of enrolling babies born in another state without need for a new application. Although the statutory language refers to deemed eligibility under "such state plan" referring back to the state plan under which the mother was covered by Medicaid, to read this language so narrowly would restrict the rights of mothers and children to travel among states, similar to a durational residency requirement.

Section 1902(e)(4) of the Act provides that for the year of deemed eligibility, the Medicaid identification number of the mother serves as the identification number of the child for Medicaid claims purposes, unless the state issues the child a separate identification number. For babies eligible under proposed §435.117, proposed paragraph (d)(2) directs the agency to promptly issue a separate Medicaid identification number for the child prior to the date of the

child's first birthday or the termination of the mother's Medicaid eligibility, whichever is sooner, unless the child is determined to be ineligible (such as, the child is not a state resident).

Finally, section 1902(e)(4) of the Act does not distinguish between babies born to pregnant women eligible for Medicaid as medically needy under section 1902(a)(10)(C) of the Act and those born to pregnant women eligible for Medicaid as categorically needy under section 1902(a)(10)(A) of the Act. We propose to revise existing regulations at §435.301 by removing paragraph (b)(1)(iii), which provided that babies born to medically needy pregnant women receive deemed newborn eligibility as a medically needy child. Under revised §435.117, as proposed in this rulemaking, babies born to pregnant women eligible as medically needy and receiving covered benefits for the date the child is born are covered as deemed newborns under §435.117. These proposed changes are consistent with current policy, clarifying and simplifying them, and should have no meaningful impact on state programs.

(ii) CHIP Deemed Newborn Eligibility (§457.360)

As discussed in the previous section of this preamble, section 111(a) of CHIPRA gives states the option to cover pregnant women under a separate CHIP and also adds section 2112(e) of the Act, requiring states to provide deemed newborn eligibility under Medicaid or CHIP, as appropriate based on income, to newborns of those mothers. Consistent with the proposed regulations at §435.117 for Medicaid deemed newborn eligibility discussed above, we propose a new §457.360 to extend deemed newborn eligibility under CHIP to babies born to mothers covered as targeted low-income pregnant women under a separate CHIP for the date of birth, to the extent that the state has not extended Medicaid eligibility to the babies. We are also proposing a state option to extend deemed newborn eligibility to babies of mothers covered as targeted low-income children under a separate CHIP (not as targeted low-income pregnant women) for the date of birth, to the extent that the state has not extended Medicaid eligibility to the babies. This option would relieve the state from any need to shift children from one category

to another, ensuring that benefits are delivered in the children's best interests and thus promoting the effective and efficient delivery of coverage as required by section 2101(a) of the Act. Also, we are proposing a state option to provide CHIP deemed newborn eligibility to babies of mothers who were receiving CHIP coverage in another state for the date of the child's birth or to babies of mothers covered by Medicaid or CHIP under an 1115 demonstration. As discussed above in this preamble, if the mother's household income is no more than the income standard for infants in Medicaid, the baby will be deemed eligible and enrolled in Medicaid; otherwise, the baby will be deemed eligible and enrolled in a separate CHIP.

6. Verification Exceptions for Special Circumstances (§435.952)

Under the final eligibility rule at §435.952(c), states are permitted to request additional information from individuals, including documentation, to verify most eligibility criteria if data obtained electronically by the state is not reasonably compatible with attested information or electronic data is not available, as specified in §435.952(c)(2)(ii) of the regulation. There are, however, individuals for whom providing documentation even in such limited circumstances would create an insurmountable procedural barrier to accessing coverage, while serving little evidentiary value. To ensure that verification procedures are consistent with simplicity of administration and in the best interest of individuals in accordance with section 1902(a)(19), we are proposing to add an exception at §435.952(c)(3) to an otherwise permissible requirement to provide documentation in such circumstances. Under paragraph (c)(3), except as specifically required under the Act (for example, with respect to citizenship and immigration status if electronic verification is not successful), states may not require documentation from individuals for whom documentation does not exist or is not reasonably available at the time of application or renewal. Such circumstances include, but are not limited to, individuals who are homeless and victims of domestic violence or natural disasters.

7. Verification Procedures for Individuals Attesting to Citizenship or Satisfactory Immigration Status

Verification of citizenship and immigration status is governed by sections 1137, 1902(a)(46)(B), 1902(ee), and 1903(x) of the Act, and by section 1943 of the Act, which cites to section1413(c) of the Affordable Care Act. Implemented in current regulations at §435.406, section 1137 of the Act requires that individuals seeking an eligibility determination make a declaration of citizenship or immigration status, and that the status of non-citizens be verified with the Department of Homeland Security (DHS). Under section 1902(a)(46)(B), states must verify citizenship status of applicants either by use of documentary evidence in accordance with section 1903(x) of the Act or through an electronic data match with the Social Security Administration (SSA) under section 1902(ee) of the Act, as added by section 211 of CHIPRA. Documentation of citizenship status under section 1903(x) is implemented in current regulations at §435.407. Section 211 of CHIPRA also made other changes to section 1903(x), for example, exempting infants deemed eligible for Medicaid under section 1902(e)(4) of the Act from the requirement to verify citizenship, and adding a statutory requirement to provide for a "reasonable opportunity" period for individuals declaring U.S. citizenship to provide verification, similar to the "reasonable opportunity" afforded individuals declaring satisfactory immigration status under section 1137(d) of the Act. We propose revisions to §435.406 and §435.407 of the current regulations and §435.956 of the Medicaid eligibility final rule in order to implement section 1902(ee) of the Act and other revisions to section 1903(x) of the Act made by CHIPRA, as discussed below and note that we redesignate the definition of "citizenship" from the introductory paragraph at §435.407 to a definition at §435.4.

a. Electronic Verification of Citizenship and Immigration Status (§435.940 and §435.956)

Under §435.949 of final Medicaid Eligibility Rule, the Secretary will establish an electronic service (referred to as the "federal data services hub") through which all insurance affordability programs can access specified data from pertinent federal agencies needed to verify eligibility. Per §435.949, if information related to verifying Medicaid eligibility – including information to verify citizenship from SSA and information to verify immigration status from DHS – is available through the federal data services hub described in §435.949, states will be required to obtain such information through that service. We therefore clarify at proposed §435.956(a)(1) that states will be required to verify citizenship and immigration status through the federal data services hub if available.

Prior to passage of the Affordable Care Act, section 211 of CHIPRA, which added section 1902(ee) to the Act, has provided states with an option to conduct an electronic data match directly with SSA to satisfy the citizenship verification requirements in lieu of requiring documentation in accordance with section1903(x) of the Act. To date, 44 states have adopted this option in their Medicaid and CHIP programs. Although states will be required to conduct electronic verification of citizenship primarily through the federal data services hub, if such verification is not available, the option under section 1902(ee) of the Act will remain in effect.

If the agency is unable to verify such status through the hub, proposed §435.956(a)(2) directs the agency to verify citizenship by conducting an electronic data match directly with SSA or by obtaining documentation in accordance with §435.407 of the regulations, as modified in this proposed rulemaking, and to verify immigration status by conducting a match directly with DHS' SAVE system in accordance with section 1137 of the Act and §435.406. In such instances, verification of citizenship and immigration status should be conducted in a manner consistent with the requirements of §435.952(c)(2)(ii) of the final eligibility rule (permitting states to require documentation to verify an eligibility criterion only if electronic data is not available, as defined in the regulation). Note that some of the documentary evidence permitted

under section 1903(x) of the Act and §435.407 to verify citizenship may be available electronically, such as a match with a state's vital statistics agency, and such data also must be accessed when available under the standard established in §435.952(c)(2)(ii) before paper documentation of citizenship is requested.

Under 8 USC 1613(b)(2), qualified non-citizens who are veterans with a discharge characterized as a honorable discharge and not on account of alienage and who fulfill the minimum active-duty service requirements of section 5303A of Title 38 or are in active military duty status (other than active duty for training), or the spouse or dependent child of such a veteran or individual in active duty status, are exempt from the 5-year waiting period applicable to certain qualified non-citizens. We seek comment on appropriate verification procedures for veteran status.

In proposed §435.956(a)(3), we move and revise current language at §435.407(i)(5), which provides that verification of citizenship (whether through documentation submitted by the applicant or through an electronic data match) is a one-time activity that should be recorded in the individual's file. At a regular eligibility renewal or as part of a future application for Medicaid, the agency may not re-verify citizenship, but must only check its records to confirm that the individual's citizenship has already been verified. We expect that states will re-verify an individual's immigration status if the status is temporary in nature, such as for individuals in Temporary Protected Status. We solicit comments on whether, consistent with existing regulations at §431.17(c), Medicaid agencies should be expected to retain such records indefinitely or for a more limited period of time, such as 5 or 10 years.

b. Reasonable Opportunity to Verify Citizenship or Immigration Status

We anticipate that electronic verification with SSA or DHS generally will occur in real or near-real time. In the event that electronic verification through the hub or another source is delayed or fails, sections 1903(x) and 1902(ee) of the Act require that states provide applicants

declaring U.S. citizenship with a "reasonable opportunity period" to verify their citizenship. During the reasonable opportunity period, states must try to resolve with SSA or the applicant inconsistencies that arise from the data match, and request additional documentation from the applicant if the inconsistencies cannot be resolved. Under sections 1902(ee) and 1903(x) of the Act, states also must furnish Medicaid to otherwise eligible individuals during the reasonable opportunity period. As noted, section 1137(d)(4) of the Act similarly requires states to provide individuals with a "reasonable opportunity" to establish satisfactory immigration status if documentation is not provided or verification of satisfactory immigration status with DHS fails, and to receive benefits if otherwise eligible during such time. Section 1411(e)(3) of the Affordable Care Act requires Exchanges to verify an individual's attestation of citizenship and lawful presence in the same manner as Medicaid in accordance with section 1902(ee) of the Act when inconsistencies arise. We anticipate that in many cases states may be able to resolve inconsistencies in real-time or near real-time, in which cases the reasonable opportunity period would not need to be triggered.

In accordance with sections 1137, 1902(ee), and 1903(x) of the Act, we propose to add a new paragraph (g) to §435.956 to implement the reasonable opportunity period afforded to individuals who declare U.S. citizenship or satisfactory immigration status. Under §435.911(c) of the final Medicaid Eligibility Rule (revised to update a cross reference in this proposed rule), states must provide benefits to otherwise eligible individuals during such reasonable opportunity period. Situations which may trigger the reasonable opportunity period include the following:

- The individual is unable to provide a SSN, needed for electronic verification with SSA;
- Either the federal data services hub or SSA or DHS databases are temporarily down for maintenance or otherwise unavailable, thereby delaying electronic verification;

- There is an inconsistency between the data available from an electronic source and the individual's declaration of citizenship or immigration status which the agency must attempt to resolve, including by identifying typographical or clerical errors; or
- Electronic verification is unsuccessful, even after agency efforts to resolve any inconsistencies, and additional information, including documentation, is needed.

Recognizing that electronic verification of citizenship and immigration status generally will be accomplished in real-time, we further propose that the reasonable opportunity period is triggered if verification of citizenship or immigration status cannot be concluded "promptly." This standard is consistent with the standard applied to the provision of benefits generally under §435.911(c) of the final Medicaid Eligibility Rule, pursuant to which individuals must be furnished benefits "promptly and without undue delay." We expressly apply the standard in §435.911(c) to the provision of benefits to individuals during a reasonable opportunity period by including a cross reference to §435.911(c) at proposed §435.956(a)(2)(ii). Thus, if the agency cannot resolve inconsistencies in a data match with SSA or DHS (performed either in accordance with §435.949 of the final Medicaid eligibility final rule or proposed §435.956(a)(1) or (2)) in a prompt manner, such that eligibility would be determined and benefits provided with the same promptness as if the agency were able to verify citizenship or immigration status in real-time, the agency must begin the reasonable opportunity period, and benefits must be furnished as soon as other eligibility criteria are verified, in the same manner and as promptly as such criteria are verified for applicants generally. In the case of an individual with respect to whom a temporary immigration status was verified at application and with respect to whom the agency is re-verifying satisfactory status, regulations at §435.911(c) in the Medicaid eligibility final rule similarly require that benefits be furnished during the reasonable opportunity period afforded under §435.956(g). We note that in the case of a reasonable opportunity period triggered because the applicant is unable to provide an SSN, resulting in the state's inability to initiate

electronic verification of citizenship with SSA, states must comply with the regulations at §435.910, relating to assisting individuals with obtaining and verifying SSNs. We also note that we are making a technical correction to §435.910(g) to put back the reference to the verification of SSNs with SSA, which was inadvertently deleted in the Medicaid eligibility final rule.

We propose a conforming amendment to §435.911(c) of the final Medicaid eligibility final rule to clarify that the reasonable opportunity period encompasses all aspects of the process to verify citizenship immigration status, including not only time for an individual to provide documentation but also time for the agency to resolve inconsistencies or conclude the electronic verification process. This proposed rulemaking also replaces the cross reference in §435.911(c) of the Medicaid eligibility final rule to the statutory provisions governing the reasonable opportunity period with a cross reference to §435.956(g), as proposed in this rulemaking.

The proposed rule seeks to balance individuals' ability to access coverage in a timely manner and states' administrative interests in not being required to take steps to enroll someone in the program immediately whenever electronic verification is not accomplished in real time, if inconsistencies can be resolved quickly. We note that section 1137(d)(4) of the Act seems to require a reasonable opportunity period only in cases where the individual has either not provided documentation or where verification with DHS has failed. This seems to indicate that states have at least the option of some reasonable time during which they can attempt to resolve inconsistencies and verify immigration status prior to providing the reasonable opportunity period, including the provision of benefits. Similarly, section 1902(ee)(1)(B)(ii) discusses the reasonable opportunity period only once an inconsistency in verification cannot be resolved, which is consistent with the proposed policy. We also are considering a policy – either instead of or in addition to the policy described above – under which the reasonable opportunity period, including provision of benefits during such period, would be triggered if the agency cannot

resolve any inconsistencies with the electronic match with SSA or DHS within a specified number of business days. We seek comments on both approaches.

We propose to apply the same reasonable opportunity period of 90 days that is required under section 1902(ee) of the Act, and which also is required for Exchanges, to all citizenship verification procedures, whether conducted in accordance with §435.949, section 1902(ee) of the Act, or §435.407. We are also proposing this same 90-day timeframe to verifying an individual's satisfactory immigration status in accordance with §435.949, §435.406 or section 1137(d) of the Act. This will provide for consistency and ease of administration and coordination between insurance affordability programs and better understanding by the public.

Proposed §435.956(g)(1) establishes the basic requirement to provide a reasonable opportunity to individuals to verify citizenship or immigration status as well as notice of such opportunity. We propose in paragraph (g)(2) that the reasonable opportunity period extends 90 days from the date on which such notice is received by the individual. We are proposing to define the date the individual receives the notice to mean 5 days after the date on the notice, unless the individual shows that he or she did not receive the notice within the 5-day period, consistent with the proposed revision to §431.231 (relating to receipt of notice of an individual's right to appeal). We also propose (1) to codify current policy, outlined in previous CMS guidance (SHO-09-016, SMD 06-012), to permit states to extend the reasonable opportunity period if the agency needs more time to complete the verification process, or the individual requests more time and is acting in good faith to obtain the necessary documentation; and (2) to permit states to begin furnishing benefits during the reasonable opportunity period as early as the later of the date of application or declaration of status; however, the 90-day period provided to the individual to furnish necessary evidence must always be counted from the date notice of the reasonable opportunity period is received.

As noted, during the reasonable opportunity period, if electronic verification directly with SSA or DHS is not successful, the agency must first utilize other available data sources (for example, a data match with vital statistic records of birth or the Office of Refugee Resettlement telephone line) to verify citizenship or immigration status, in accordance with §435.952(c)(2)(ii), prior to seeking additional information or documentation from an individual. If citizenship or immigration status has not been verified through efforts by the agency and satisfactory documentation has not been provided by the individual by the end of the reasonable opportunity period, the agency must take action to terminate benefits. The agency must provide timely notice and fair hearing rights in accordance with part 431 subpart E, except we are proposing that the provisions at §431.230 and §431.231 relating to maintaining and reinstating services may be applied at state option. We believe making these provisions applicable at state option is legally permissible under section 1902(a)(3) of the Act, as well as relevant case law on the procedural rights associated with denials or terminations. Thus, once the individual has been provided benefits during a reasonable opportunity, the state may consider the individual to be a beneficiary, eligible for continued benefits pending the outcome of an appeal denying eligibility. On the other hand, individuals provided benefits during a reasonable opportunity period have not actually been determined eligible for Medicaid, as their citizenship or immigration status has not been established. Therefore, once the reasonable opportunity period is over, we believe the state can treat such individuals the same as those denied eligibility for any other reason, which are not eligible for benefits pending the outcome of a fair hearing. Further, the availability of the reasonable opportunity period, and the fact that an otherwise eligible individual is provided eligibility during such period, reduces risk of error that eligible individuals will be denied or delayed benefits, as well as the probable value of additional procedural safeguards of maintaining services pending the outcome of a fair hearing. Thus, once a state has (a) already attempted to resolve discrepancies associated with verification, (b) turned to other electronic data

sources if verification with DHS or SSA is unsuccessful, (c) offered an opportunity for the individual to resolve discrepancies or provide alternative documentation of status, including (d) during a reasonable opportunity period during which benefits are furnished as long as the individual meets all other eligibility criteria, the state may legitimately conclude that the marginal value of providing continued benefits to the individual pending appeal does not outweigh the cost to the state associated with maintaining services and reinstating services retroactive to the date or termination if the individual should prevail on his or her appeal.

We note that the requirement to provide a reasonable opportunity period for citizens and nationals under CHIPRA took effect on July 1, 2006, however our proposal to define the length of such period—other than those done through the process described in section 1902(ee) of the Act, for which the 90-day timeframe also went into effect in January 1, 2010 with the passage of CHIPRA—will take effect in January 2014.

Finally, we propose to amend §435.1008 to reflect the statutory requirement that states are entitled to receive federal financial participation (FFP) for benefits provided to individuals declaring U.S. citizenship or satisfactory immigration status during the reasonable opportunity period, regardless of whether eligibility ultimately is approved for such period.

c. Changes to and Clarification of Current Policy (§435.3, §435.406, and §435.407)

Section 211 of CHIPRA also made several technical corrections and amendments to section 1903(x) of the Act. On December 28, 2009, CMS issued a state Health Official Letter, SHO #: 09-016, providing guidance regarding section 211 of CHIPRA (http://www.cms.gov/smdl/downloads/SHO122809corrected.pdf). We propose to codify key aspects of that guidance in this rulemaking, as described below. These proposed changes clarify current policy and will not significantly impact current state programs.

(i) Exemption from Citizenship Verification Requirement for Deemed Newborns (§435.406, §457.380)

Section 211(b)(3) of CHIPRA amends section 1903(x) of the Act to exempt from the citizenship verification requirement children eligible for Medicaid under 1902(e)(4) of the Act and §435.117 because their mothers are covered for the child's birth under Medicaid. Such children (often referred to as "deemed newborns") are not required to document or verify citizenship at birth or at any subsequent determination or redetermination of eligibility, including after a break in coverage. As allowed by section 1903(x)(2)(E) of the Act, under 435.406 (a)(1)(iv)(E), we propose that information from the state's separate CHIP as well as information from another state that the individual was deemed eligible as a newborn under either Medicaid or CHIP in that state also serves to exempt the individual from the requirement to document citizenship. This policy satisfies the intent of section 211(b)(3) of CHIPRA that evidence of deemed newborn eligibility for Medicaid is sufficient evidence of citizenship. Under section 1903(x)(5)of the Act, proposed §435.406 (a)(1)(iv)(E) applies equally to children born to non-citizen mothers covered only for labor and delivery or other emergency services. We propose at §457.380 also to apply this exemption to CHIP based on the authority given the Secretary under section 1903(x)(2)(E) of the Act (as incorporated in CHIP under section 2105(c)(9)) to specify the bases under which satisfactory documentary evidence of citizenship or nationality previously has been presented.

(ii) Types of Acceptable Documentary Evidence of Citizenship and Identity (§435.407)

The current regulations implementing section 1903(x) of the Act, as in effect prior to CHIPRA were designed to reduce Medicaid costs and prevent coverage of individuals who were in the country illegally (72 FR 38688 through 38689). A report by the Government Accountability Office (GAO) indicates that state experience since the regulations were published has demonstrated that very few undocumented individuals apply for Medicaid or falsely claim U.S. citizenship (June 2007, GAO-07-889). The report and other reports from government and non-profit organizations and on state experiences confirms, that, as implemented, the current

regulations have resulted in an increase in administrative costs as well as in large numbers of eligible citizens, especially children, being inappropriately denied coverage, or their enrollment in Medicaid delayed.

In light of these findings, we are proposing to modify the regulations governing the verification of citizenship and identity under section 1903(x) of the Act in the event citizenship cannot be verified through the federal data services hub or an electronic data match directly with SSA, by eliminating non-statutory requirements in the current regulations that increase administrative burden and create unnecessary barriers to successful documentation, without compromising program integrity.

We are eliminating the 4-tier structure in the current regulation and instead propose an approach that is consistent with section 1903(x) of the Act, which establishes 2 tiers of documents: (1) those that provide evidence of citizenship; and (2) those that provide evidence of citizenship but require an additional identity document.

In §435.406 of the current regulations, we propose to:

- Revise the introductory paragraph (a) to replace the phrase "residents of the United States" with "individuals" to clarify that §435.406(a) pertains to an individual's eligibility based on citizenship or non-citizen status, not residency (standards regarding state residency are at §435.403);

- Revise paragraphs (a)(1)(i) and (ii) to replace the reference to section 1137 of the Act with a cross reference to §435.956(a), as proposed in this rulemaking.

- Add a new paragraph (a)(3) to revise who is permitted to make the declaration of citizenship or immigration status required under section 1137 of the Act to include: the individual, or an adult member of the individual's family or household; an authorized representative; and, if the applicant is a minor or incapacitated, someone acting responsibly for the applicant. The proposed revisions aim to align with the regulation at §435.907 of the

Medicaid eligibility final rule regarding who is permitted to submit an application on behalf of another individual. Under proposed §435.406(a)(3), in order for another person to declare citizenship or immigration status on behalf of the applicant, the person must attest to having a reasonable basis for making such declaration, such as personal knowledge that the individual is a citizen or national or in satisfactory immigration status.

- Delete the word "recipients" from paragraph (a)(1)(iii) to reflect the policy, discussed above, that verification of citizenship is a one-time activity and therefore only applies to first time applicants.

- Delete paragraph (a)(1)(iv) and redesignate paragraph (a)(1)(v) at (a)(1)(iv) because we have moved the requirement to document the verification of citizenship in the individuals file to §435.956, and as noted existing regulations provide that re-verification of citizenship at regular renewals is not needed.

In §435.407(f) of the revised regulations, we propose to remove the requirement that individuals must provide an original copy of documents, and replace it with a requirement that states accept photocopies, facsimiles, scanned or other copies of documents, unless information on the copy is inconsistent with information available to the agency, or the agency otherwise has reason to question the validity of the information on the document. Originals are not required under the statute, have not been shown to enhance program integrity, undermine potential for a real-time online user experience involving electronic submission of documents as well as submission of complete applications by mail, and lead to increased administrative costs since states must return the originals. We also propose to eliminate the requirement that records – such as medical, school or religious records – containing information regarding an individual's place of birth be created within a certain period of time before the date of application, and to permit states to maintain a record (including an electronic record) of a successful verification in lieu of maintaining paper copies of proof of citizenship, consistent with section 1943 of the Act

and section 1413 of the Affordable Care Act. These, and other proposed revisions to simplify the existing regulations in accordance with Executive Order 13563's call for streamlining and updating regulations to reduce administrative burden on states and consumers, in order of paragraph letter, are as follows.

In paragraphs (a) through (e) of §435.407, we remove all references in §435.407 to forms and form numbers and who can issue certain forms, all of which are subject to change, for example, the Immigration and Naturalization Services (INS) is now part of the Department of Homeland Security (DHS), and such information is not relevant to the probative value of the documents as evidence of citizenship; delete from the list of acceptable documents passports issued through 1980 that may have included several members of the family, as such passport has not been issued for over 30 years; delete repetitive, extraneous or obsolete language, including reference to individuals born in Guam on or after April 10, 1899 since that would encompass everyone at this time, and the delayed effective date for reliance on Enhanced Driver's Licenses, which some states have begun to issue, and references to tribal documents in paragraphs (b), (d) and (e) which will be encompassed under a new paragraph (a)(5), discussed below.

In §435.407(a) we also propose revisions to the list of documents that can be used to prove citizenship without separate proof of identity to add:

- At paragraph (a)(1), a U.S. Passport Card, which is issued to U.S. citizens for travel across land or sea borders to Canada, Mexico, the Caribbean, and Bermuda, and delete language discussing certain passports issued through 1980 since such passports have not been issued for over 30 years; and

- At paragraph (a)(5)(i), add documents issued by a federally-recognized Indian tribe showing membership, enrollment or affiliation with such tribe to the list of primary evidence of citizenship and identity, as required under the amendments to section1903(x) of the Act made by section 211 of CHIPRA (effective July 1, 2006, as if included in the Deficit Reduction Act of

2005) and consistent with the policy set forth in the December 28, 2009 SHO Letter (SHO #09-016). We propose at §435.407(a)(5)(ii) that such documents include, but are not limited to, those identified in SHO #09-016. We note that this list is not exclusive of other tribal documents and, as tribes are individual independent governments which may not have uniform methods of documenting membership, enrollment, or affiliation with a particular tribe, we encourage states to work with tribes located within their borders to identify additional documents used by those tribes to establish tribal membership.

Section 1903(x)(3)(B)(v)(II) of the Act directs the Secretary, after consultation with the tribes, to determine the documentation necessary for federally recognized Indian tribes located within states having an international border and whose members include individuals who are not U.S. citizens. Under section 402 of PRWORA, 8 USC 1612, individuals who can demonstrate that they are members of an Indian Tribe, as defined in 25 U.S.C. 450b(e), and are not citizens, are eligible for Medicaid without being subject to the 5-year waiting period. Section 402 of PRWORA does not distinguish between cross-border and intra-border tribes. Accordingly, we propose in §435.407(a)(5) to permit individuals who declare they are citizens and also members of an Indian tribe to rely on the same tribal documents discussed above, regardless of whether the tribe is located in a state with an international border. In making this proposal, we have engaged in the consultation discussed above but invite further comment on this proposal.

We reorganize the list of documents in current paragraph (b) and consolidate and streamline the regulation text currently at §435.407(c) and (d) in the revised paragraph (b). We propose that revised paragraph (b) would reflect all documents that may be used, along with proof of identity, to verify citizenship and we eliminate the tiered levels of documents in the current regulations. We also eliminate the requirement that, to rely on a document listed in paragraph (b), an applicant must first show that no document listed in paragraph (a) is available. Other changes to paragraph (b) are as follows:

We add a new paragraph (b)(2) to move current language in (b)(1) that states may use a cross match with a state vital statistics agency to document a birth record. Reference to original documents in paragraph (b)(8) also is removed, as is the requirement in redesignated paragraph (b)(13) that a hospital record of birth be on hospital letterhead, as electronic hospital records may not contain letterhead. In redesignated paragraph (b)(15), we eliminate the "caution" regarding "questionable cases" as such cases will now be addressed in revised paragraph (f), discussed above, as well as the requirement that the religious record has to show the applicant's date of the birth or age at the time the record was made, since this detail is not required for other acceptable documents. We revise redesignated paragraph (b)(16) to remove the requirement that a school record be an "early" record, and contain the date of admission to the school, date of birth, and names of parent's and places of the parent's births. A school record need only contain information of place of U.S. birth. We remove from redesignated paragraph (b)(17) the requirement that a census record must show the applicant's age. Section 435.407(d)(2)(v) of the current regulations is deleted because a statement signed by a physician or midwife who was in attendance at the time of the birth would be encompassed under the new proposed paragraph (b)(18) described below, which would allow for signed statements or affidavits.

New paragraph (b)(18) replaces current paragraphs (d)(2)(v) and (d)(5) to simplify the requirements governing use of affidavits to document citizenship. Under proposed paragraph (b)(18), an individual who does not have one of the documents listed in paragraph (a) or paragraphs (b)(1) through (17) may submit an affidavit, containing the individual's name, date of birth, and place of U.S. birth by someone who can reasonably attest to the individual's citizenship. Other restrictions on the use of affidavits, such as there needing to be two affidavits signed by two individuals who have personal knowledge of the individual's birth, and that individual signing the affidavit must prove their citizenship, are eliminated as creating unnecessary barriers to enrollment for eligible applicants and not required under the statute.

However, we seek comment on whether two rather than one affidavit is warranted. We are maintaining the current policy that the affidavit does not need to be notarized.

Section 435.407(e), relating to documentation of identity, is redesignated at paragraph (c). We propose language in paragraph (c)(1) that the documents to prove identity must contain a photograph or other identifying information including, but not limited to, name, age, sex, race, height, weight, eye color, or address. With this statement we are deleting all references currently in §435.407(c) that specific documents must include this information. We clarify at redesignated (c)(1)(i) that a driver's license issued by a Canadian government authority is not a satisfactory document for proving identity in the U.S. We also delete the current language related to tribal documents, which now serve as acceptable evidence of citizenship under paragraph (a)(5). Use of medical and school records to establish a child's identity is moved to paragraph (c)(2), where we also propose to change the age limit applicable to use of such records from under age 16 to age 19 to align the age limit used in CHIP, and to remove the requirement on states to independently verify such records. In redesignated paragraph (c)(3), we propose to reduce the number of corroborating documents from three (in existing paragraph (e)(3)) to 2, and require states to accept them if presented by an applicant based on the authority of section 1903(x)(3)(B(vi) of the Act for the Secretary to prescribe other documents for verifying citizenship and identity. We streamline the language in redesignated paragraph (c)(4), relating to the permissibility of states' relying on a finding of identity by another federal or state agency, and add a new paragraph (c)(5) to permit reliance on a finding of identity from an Express Lane agency, as defined in section 1902(e)(13)(F) of the Act, regardless of whether or not the state otherwise has exercised the option under section 1902(e)(13) of the Act to rely on any findings of such agency in determining Medicaid eligibility. We also propose to remove the sentence requiring the Medicaid agency to assure the accuracy of the identity determinations since this provision allows the Medicaid agency to rely on the findings of another state agency. We also

consolidate at redesignated paragraph (c)(6), the permissible use of affidavits to establish identity in the current regulations at §435.407(f) and (g) to apply more broadly to anyone unable to produce other identity documentation, provided that the affiant can reasonably attest to the applicant's identity, consistent with our proposal for affidavits demonstrating citizenship. Because we propose to move the current content of paragraphs (f) and (g) of existing §435.407 to other sections, current §435.407(f) and (g) are deleted in this proposed rulemaking.

To further expand the options states have to verify citizenship, we add a new paragraph (d) to §435.407 to permit reliance on verification of citizenship by another state, provided such verification was made on or after July 1, 2006, when the requirement to verify citizenship under section 1903(x) of the Act went into effect.

Building on previous policy outlined in the June 9, 2006 State Medicaid Directors Letter, 06-012), and the 2007 final rule regarding Medicaid citizenship documentation requirements (72 FR 38662, §435.407(e) (redesignated from paragraph (h) of the current regulations) is revised to clarify that states must provide individuals needing assistance in obtaining required documentation. The language in the current regulation at §435.407(h) provides that assistance be available to individuals who are unable to secure documentation due to "incapacity of mind or body" and who do not have a representative of their own to provide the help needed. This language is simplified in this proposed rule at §435.407(e) to reflect that various types of individuals may need assistance in obtaining documentation of their citizenship, even if not "incapacitated" (for example, disabled, limited English proficient and homeless individuals and victims of natural disaster). This simplification also removes the requirement that someone needing assistance to first demonstrate that they are mentally or physically incapacitated. We also note that, due to the increased use of electronic data sources to verify citizenship, we anticipate the number of individuals needing assistance in obtaining documentation to be minimal.

As discussed above, we are revising §435.956 (f) (redesignated from paragraph (i)) to direct states to accept photocopies, facsimile, scanned or other copies of documents to the same extent as original documents, except when the documentation is inconsistent with other information available to the agency or the agency has reason to question the validity of the copy or information provided. We moved the language in §435.956 (i)(2) to §435.956(a)(3) related to maintaining copies of documents and revised it to permit states to maintain a record (including an electronic record) of verified citizenship in lieu of retaining paper copies in the individual's record. We propose to delete paragraph (i)(3) related to how individuals can submit citizenship documentation and that states must not require an individual to appear in person because it is redundant with language in §435.907(a) of the final eligibility rule. Section 435.907(a) allows individuals to submit all documents that are required to establish eligibility, including any documents necessary for verification of citizenship, through various modalities, including online or by mail. We also propose to remove the language in paragraph (i)(4), related to the integrity of documents presented, because it is duplicative of the program integrity requirements in Part 455 or this title governing how Medicaid agencies deal with possible incidences of fraud. Paragraph (i)(6) of the current regulations is deleted as superseded by the electronic verification processes established under section 211 of CHIPRA and through the data services hub established per sections 1412 and 1413 of the Affordable Care Act and described in §435.949 of the final eligibility rule. We propose to delete current paragraph (j) of §435.407 because 45 CFR §74.53 is not relevant to the retention of citizenship records. Finally, §435.407 (k) is deleted because we have revised and moved regulations relating to the reasonable opportunity period to verify citizenship to §435.956(g) of this proposed rule.

f. Requirement to Verify Citizenship or Nationality and Immigration Status Applied to CHIP (§457.320 and §457.380)

Section 211(c)(1) of CHIPRA amends section 2105(c) of the Act to extend the Medicaid requirement for verifying citizenship to separate CHIP programs. To codify this requirement, we propose to amend §457.320(b) and redesignated paragraph (d) of §457.380. We are also codifying previous guidance published by the Department of Justice (62 FR 61344, 63 FR 41662), the Department of Health and Human Services (63 FR 41658), and CMS (SHO January 14, 1998) that requires states to verify immigration status for any federal public benefit, which includes CHIP. We are proposing to amend §457.320 (b)(6) to indicate that a state cannot exclude otherwise eligible individuals from coverage if they are U.S. citizens or nationals, or qualified non-citizens as long as they have been verified in accordance with §457.380.

As required by CHIPRA, we are proposing to amend §457.320 to remove the option for states to accept self-attestation of citizenship to establish eligibility for CHIP. We are also proposing to revise the individuals who may declare citizenship or immigration status in the same manner that is being proposed for Medicaid at §435.406.

We propose to amend §457.380(b) to indicate that except for those populations exempt from the citizenship documentation requirement under Medicaid, states must follow the rules for verifying citizenship and immigration status in accordance with §435.956, including providing such reasonable opportunity period in accordance with §435.956(g). This change is necessary to achieve alignment between Medicaid, CHIP, and the Exchange.

8. Elimination or Changes to Unnecessary and Obsolete Regulations (§§ 435.113, 435.114, 435.201, 435.210, 435.211, 435.220, 435.223, 435.401, 435.510, 435.522, 435.909, 435.1004)

In response to the President's directive, outlined in Executive Order 13563, that agencies streamline and simplify federal regulations, we propose to revise or eliminate various current regulations, in whole or in part, as obsolete or no longer applicable. The following sections are proposed for deletion because they have been rendered obsolete due to the expansion of Medicaid coverage under the Affordable Care Act to most individuals at or below 133 percent

FPL, the de-linkage of Medicaid eligibility from receipt of AFDC, the replacement of AFDC with MAGI-based financial methodologies in CY 2014, or the proposed simplification of multiple eligibility groups:

- §435.113 (individuals who are ineligible for AFDC because of requirements that do not apply under title XIX of the Act);
- §435.114 (individuals who would be eligible for AFDC except for increased OASDI income under Pub. L. 92-336);
- §435.220 (individuals who would meet the income and resource requirements under AFDC if child care costs were paid from earnings) which we propose to replace with a new §435.220 for optional eligibility of parents and other caretaker relatives;
- §435.223 (individuals who would be eligible for AFDC if coverage under the state's AFDC plan were as broad as allowed under title IV-A of the Act);
- §435.510 (determination of dependency); and
- §435.522 (determination of age).

We propose to replace reference to "specified relatives" as used and defined in the current regulations at §435.201(a)(5), §435.301(b)(2)(ii), and §435.310 with references to "parents and other caretaker relatives," as defined at §435.4 of the Medicaid eligibility final rule. We also propose to revise §435.201 (individuals included in optional groups) to delete the reference to pregnant women, because optional groups for pregnant women will be consolidated under §435.116 in accordance with the Medicaid eligibility final rule. We propose to delete references to AFDC and to pregnant women and parents and other caretaker relatives in §435.210 (individuals who meet the income and resource requirements of the cash assistance programs), §435.211 (individuals who would be eligible for cash assistance if they were not in medical institutions), §435.401 (general eligibility requirements), §435.909 (automatic

entitlement to Medicaid following a determination of eligibility under other programs), and §435.1004 (beneficiaries overcoming certain conditions of eligibility).

9. Coordinated Medicaid/CHIP Open Enrollment Process (§435.1205 and §457.370)

Under regulations at 45 CFR 155.410, during the initial open enrollment period starting on October 1, 2013, the Exchange will begin accepting a single streamlined application for enrollment in a QHP through the Exchange and for insurance affordability programs, with enrollment effective January 1, 2014. We are proposing a new §435.1205 to similarly provide that Medicaid and CHIP agencies begin accepting the single streamlined application during the initial open enrollment period to ensure a coordinated transition to new coverage that will become available in Medicaid and through the Exchange in 2014. Proposed §435.1205 implements several provisions of the Medicaid eligibility final rule effective October 1, 2013, and ensures the coordinated and simplified enrollment system for all insurance affordability programs envisioned in section 1943 of the Act and section 1413 of the Affordable Care Act. Our proposed rule seeks to ensure that no matter where applicants submit the single, streamlined application during the initial open enrollment period, they will receive an eligibility determination for all insurance affordability programs and be able to enroll in appropriate coverage for 2014, if eligible, without delay. In addition, under the proposed rule, states will need during the initial open enrollment period to facilitate a determination of Medicaid and CHIP eligibility based on the rules in effect in 2013 when a single streamlined application is filed. We provide states with several options to ensure that individuals can be properly evaluated for eligibility under the 2013 rules, to the extent applicable, as described below.

Proposed §435.1205 (a) incorporates certain definitions and references from the Medicaid eligibility final rule which are pertinent to proposed §435.1205. Proposed §435.1205 (b) provides that pertinent provisions of the Medicaid eligibility final rule, as modified in this

proposed rulemaking, are effective as of October 1, 2013 for purposes of achieving alignment with the Exchange during the open enrollment period.

Under proposed §435.1205(c)(1), beginning October 1, 2013, state Medicaid agencies will accept (i) the single streamlined application used to make determinations for eligibility for enrollment in a QHP through the Exchange and all insurance affordability programs, or an alternative application developed by the state and approved by the Secretary per §435.907(b)(2) of the Medicaid eligibility final rule, and (ii) electronic accounts transferred from an agency administering another insurance affordability program, in accordance with 42 CFR 435.1200. We expect that utilization of the new single streamlined application will be in addition to, not in lieu of any applications currently in use by the state Medicaid and CHIP agency to determine eligibility based on 2013 eligibility rules, but are open to discussion with states on transition options, discussed below.

In proposed §435.1205(c)(2)(i), we clarify that, beginning October 1, 2013, states must begin either (I) accepting determinations based on MAGI made by the Exchange for eligibility effective January 1, 2014 or (II) receiving electronic accounts of applicants assessed as potentially Medicaid eligible by, and transferred from, the Exchange, and determine eligibility for such applicants based on MAGI and the eligibility requirements to be in effect on that date. Whether the agency begins accepting Medicaid eligibility determinations made by the Exchange or receives the electronic accounts of individuals assessed by the Exchange as potentially Medicaid eligible will depend on whether the agency has elected to delegate authority to the Exchange to make eligibility determinations under §431.10(c) of this rulemaking.

Per paragraph (c)(2)(ii), on October 1, 2013, state Medicaid agencies also will begin (I) making eligibility determinations for applicants submitting the single streamlined application to the agency, based on MAGI and eligibility criteria which will be in effect as of January 1, 2014, for coverage effective on that date and (II) assessing potential eligibility for enrollment in a QHP

through the Exchange and for other insurance affordability programs for individuals determined not Medicaid eligible by the agency, and transfer the electronic account, including the application, to such other program, as appropriate. This ensures that electronic accounts for individuals determined potentially eligible for enrollment in a qualified health plan will be transferred to the Exchange in a timely manner so that eligibility for such enrollment as well as for advance payment of the premium tax credit and cost-sharing reductions can be determined by the Exchange and plan selection and enrollment can occur in time for January 1, 2014. Per proposed paragraph (c)(2)(iii), states also will need to provide notice and fair hearing rights consistent with part 431 subpart E of the regulations, as revised in this rulemaking, and §435.1200 of the Medicaid eligibility final rule, as also revised in this proposed rulemaking, regarding coordination of eligibility determinations, notice and appeals with the Exchange and with agencies administering other insurance affordability programs.

Proposed §435.1205 (c)(3)(i) provides that, for each individual determined eligible for Medicaid by the agency or the Exchange per proposed paragraph (c)(2)(i) or (ii), the agency must furnish Medicaid effective January 1, 2014. Per proposed paragraph (c)(3)(ii), the terms of §435.916 of the Medicaid eligibility final rule (relating to beneficiary responsibility to inform the agency of any changes in circumstances that may affect eligibility) and §435.952 of the Medicaid eligibility final rule (regarding use of information received by the agency) apply such that individuals determined eligible during the initial open enrollment period for coverage effective January 1, 2014 must report changes in circumstances that may affect their eligibility, and the agency must evaluate the impact of such changes on eligibility, consistent with §435.952. Under the proposed regulation, the agency has the option to schedule the first regular renewal under §435.916 for individuals applying during the open enrollment period and determined eligible effective January 1, 2014, to occur anytime between 12 months from the date of application and January 1, 2015. States may also conduct post-eligibility data matching to

ensure continued eligibility as of January 1, 2014 and/or through the first regularly-scheduled renewal.

Given the outreach efforts anticipated around the single, streamlined application and the initial open enrollment period, some people who are eligible for Medicaid under 2013 rules can be expected to apply using the single, streamlined application. While Medicaid agencies are not required to adjudicate 2013 eligibility for applicants who apply using the single, streamlined application, we propose at §435.1205(c)(4) that states establish a process to ensure that individuals submitting the single streamlined application can be evaluated and determined eligible for coverage effective in 2013. States are encouraged, but not required, to determine eligibility effective in 2013 based on the information provided on a single streamlined application, or to adopt a supplemental form or questions to obtain any additional information needed to do so. Specifically, we propose in §435.1205(c)(4)(i) that the agency may determine an applicant's eligibility for 2013 based on the information gathered as part of the single streamlined application if the agency has sufficient information to make such a determination, or request any additional information (through, for example, use of a supplemental form) needed to do so, providing notice and appeal rights in accordance with the regulations. Alternatively, per proposed §435.1205(c)(4)(ii), the agency may notify individuals submitting the single streamlined application during the initial enrollment period that to be considered for eligibility in 2013 they must submit a separate application for coverage and provide information on how to obtain and submit such application. We request comment on whether states should only notify a subset of applicants about the process to apply for coverage with an effective date in 2013 – for example only those applicants who appear, on the basis of available information provided on the single streamlined application, to be potentially eligible under 2013 rules.

Given the value of implementing a coordinated the eligibility and enrollment process for enrollment in a QHP through the Exchange and all insurance affordability programs during the

initial open enrollment period, we are considering, for purposes of the initial open enrollment period, whether, in addition to proposed §435.1205 and §457.370, to make some or all of the following sections of the regulations, as promulgated or revised in the Medicaid eligibility final rule or as proposed or revised in this rulemaking, effective October 1, 2013, or whether an effective date of January 1, 2014 for some or all of these sections is appropriate: §431.10 and §431.11 (relating to the delegation of authority to the Exchange or Exchange appeals entity to determine eligibility and conduct fair hearings); §435.603 (MAGI-based methodologies) and §435.911 (MAGI screen) for purposes of making eligibility determinations effective prior to January 1, 2014 prior to that date; §435.907 (use of the single streamlined application); §435.908(c) (use of application assisters) and §435.923 (use of authorized representatives); §§435.940 et seq. (verification of eligibility criteria); §§431.200 et seq., §435.917 §435.918 and §435.1200 (coordination of eligibility and enrollment, notices and appeals between the Exchange, Medicaid and CHIP); and corresponding CHIP regulations in part 457 (§§457.315, 457.330, 457.340, 457.348, 457.350, 457.351, 457.380 and 457.1180). We solicit comments on the appropriate effective date for these sections to ensure a smooth initial open enrollment period.

We will also work with states interested in not having to assess eligibility during this limited time period based on two different sets of rules. For example, some states have expressed interest in using the authority of section 1115 of the Act to apply MAGI-based methods to determinations of Medicaid eligibility effective with the 2013 open enrollment period, or in more closely aligning current financial methodologies with MAGI-based methods through adoption of less restrictive methods under their state plan. CMS is open to working with states to effectuate these or other ideas states or other stakeholders may have to achieve coordination with the Exchange and minimize administrative and consumer burden during the 2013 open enrollment period.

Finally, during the initial open enrollment period and likely at least through 2014, some individuals may submit the application used by the state to determine eligibility using 2013 rules. We seek comment on the best ways for states to ensure that individuals submitting such applications during the initial open enrollment period are evaluated for coverage effective January 1, 2014, and thereafter, to ensure that state Medicaid agencies obtain such additional information as is necessary to determine whether such individuals are eligible for Medicaid using the MAGI-based standards, methodologies and eligibility categories for coverage effective on January 1, 2014.

Like Medicaid, a separate CHIP program will need to align with the Exchange's initial open enrollment period. We propose a new §457.370 to apply the same provisions to states administering a separate CHIP as proposed for Medicaid at §435.1205.

10. Children's Health Insurance Program Changes

a. CHIP Waiting Periods (§457.805)

The Affordable Care Act promotes enrollment in and continuity of coverage. CHIP was created in the absence of the Affordable Care Act and allows states to require periods of uninsurance between disenrollment from private group health coverage and the beginning of enrollment in CHIP (often referred to as "waiting periods"). Waiting periods have been permitted, although are not required, under section 2102(b)(3)(C) of the Act, which requires states to ensure that coverage provided under CHIP does not substitute for (or "crowd out") coverage under group health plans. Implementing regulations at §457.805 specify that CHIP state plans must include a description of "reasonable procedures" to prevent substitution. Some 38 states currently employ waiting periods – ranging from one to twelve months in duration, with various state-specified exceptions – as a mechanism for preventing such substitution.

While not directly addressed in our earlier regulations, we received a number of comments suggesting that CHIP waiting period policies should be revised. Although waiting

periods are a common strategy in CHIP, states have other options to prevent substitution of coverage. CHIP waiting periods create gaps in coverage that exceed standards established under the Affordable Care Act. Section 1201 of the Affordable Care Act amends section 2708 of the Public Health Service Act to prohibit waiting periods exceeding 90 days for health plans and health insurance issuers offering group or individual coverage, a standard which, though not directly applicable to CHIP, is exceeded in roughly half of the states with a CHIP waiting period. If permitted to continue, children eligible for a separate CHIP program would be the only population subject to waiting periods that exceed 90 days starting in 2014. In addition, section 5000A of the Internal Revenue Code, as added by section 1501 of the Affordable Care Act, applies the requirement to maintain "minimum essential coverage" to both adults and dependents. In families that choose to enroll children in coverage through the Exchange during a waiting period, the child may experience disruption of care when the waiting period, and therefore, availability of the premium tax credit ends and enrollment in CHIP occurs. Coordination between the CHIP agency and the Exchange will be needed. To effectuate this transition, we propose revising §457.350(i) to include those individuals subject to a waiting period within the requirement to screen for potential eligibility for other insurance affordability programs. For individuals subject to a waiting period, under proposed revisions at §457.350(i)(3), states also would need to notify such program of the date on which such period ends and the individual is eligible to enroll in CHIP. In an effort to balance the goals of permitting states flexibility to employ waiting periods to prevent substitution of coverage and eliminating barriers and promoting continuity of coverage, and based on the authority provided in sections 2102(b)(3)(E) and 2102(c)(2) of the Act (requiring that states institute procedures to ensure coordination between CHIP and other public and private coverage programs for low-income children) and sections 1943 and 2107(e)(1)(O) of the Act and section 1413 of the Affordable Care Act (requiring coordination of eligibility and enrollment between all insurance

affordability programs), we are proposing to allow waiting periods in CHIP with limitations effective January 1, 2014.

Specifically, we propose revisions to existing regulations regarding prevention of substitution of coverage at §457.805 to retain the ability of states to impose a waiting period, but limit any waiting period to a maximum of 90 days. States would retain the ability to grant state-defined exemptions to the imposition of a waiting period. In conducting research on the use of state-defined exemptions, we found several common exemptions which we propose that all states use to waive imposition of any such period in the following situations:

(1) The cost of the discontinued coverage for the child exceeded 5 percent of household income; (2) The cost of family coverage that includes the child exceeds 9.5 percent of the household income.

(3) The employer stopped offering coverage of dependents;

(4) A change in employment, including involuntary separation, resulted in loss of access to employer-sponsored insurance (ESI) (other than through payment of the full premium by the parent under COBRA);

(5) The child has special health care needs; and

(6) The child lost coverage due to the death or divorce of a parent.

In addition, we clarify that waiting periods may not be applied to children losing eligibility for other insurance affordability programs. Further, we are considering whether to add an additional affordability exemption when the child's parent is determined eligible for advance payment of the premium tax credit for enrollment in a QHP through the Exchange because the ESI in which the family was enrolled is determined unaffordable in accordance with 26 CFR 1.36B-2(c)(3)(v).

We note that, because of the difficulty in verifying the variety of exemptions from waiting periods currently applied by states (including those described under this proposed

regulation) the FFE will not be able to make final determinations of CHIP eligibility in states choosing to impose a CHIP waiting period in 2014. Instead, the FFE would conduct an assessment of CHIP eligibility, transferring all individuals assessed as likely CHIP eligible to the CHIP agency to determine if the child meets an exemption and to make a final determination of eligibility.

We also considered proposing to limit the application of waiting periods to only children with family incomes above 200 or 250 percent of the federal poverty level, as some states currently do, as this is the population more likely to have access to affordable coverage through an employer, or only allowing waiting periods based on evidence of substitution of coverage in a state. Finally, we also considered proposing to eliminate the permissibility of waiting periods in 2014 for CHIP-eligible children. We invite comments on our proposal to allow CHIP waiting periods of up to 90 days as well as other options considered. We also solicit comments on the viability of alternative strategies to reduce substitution of coverage to best balance the goal of preventing coverage gaps for children while ensuring that CHIP coverage does not substitute for coverage available under group health plans.

Finally, we propose revising §457.810 to eliminate the required six month waiting period if a state elects to provide premium assistance through section 2105(c)(3) of the Act. Instead, we propose that any waiting period imposed under the CHIP state plan for direct coverage must apply to the same extent to the state's premium assistance program. This provision would align the rules relating to the application of waiting periods for premium assistance with those proposed for direct coverage of CHIP-eligible children at §457.805 and is consistent with the application of waiting periods in the option for premium assistance established in section 2105(c)(10) of the Act as amended by section 301 of CHIPRA. Revisions are proposed to §457.810(a)(1) and (2) and §457.810(a)(3) and(4) are deleted.

b. Limiting CHIP Premium Lock-out Periods (§457.570)

The majority (approximately 29) of states operating separate CHIPs require families to pay premiums, or enrollment fees. Over the years, states have established different disenrollment policies for non-payment of premiums and enrollment fees in CHIP.

Approximately 14 states impose a "lock-out period;" that is, a specified period of time, that a child will have to wait until being allowed to reenroll in the CHIP program after termination as a result of non-payment of premiums. In some states, this period can be until the unpaid premiums or enrollment fees are paid. In other states, the child is barred from enrollment for a period of time even if the family pays the unpaid premiums or enrollment fees. Other states require individuals to go without CHIP coverage during the premium lock-out period, but do not require families to pay their premium back at the end of the specified time. Lock-out periods currently range from 1 to 6 months. An additional 14 states require individuals to reapply for coverage and/or repay outstanding premiums in order to re-enroll in CHIP (the majority of these states require both, but a few require only one or the other), but do not characterize their programs as having lock-out periods.

We considered the impact of the use of premium lock-out periods relative to the objectives of the Affordable Care Act to promote enrollment in and continuity of coverage. Prohibiting a child from enrollment after the family pays the unpaid premium or enrollment fee is counter to promoting enrollment in and continual coverage through a streamlined eligibility process and is inconsistent with how the Exchange will address nonpayment of premiums. However, in an effort to achieve a balance between states' ability to collect premium payments and manage program costs, and the goal of removing barriers to coverage, we propose to define a premium lock-out at §457.10 as a period not exceeding 90 days when, at state option, a CHIP eligible child may not be permitted to reenroll in coverage if they have unpaid premiums or enrollment fees. We also propose at §457.570 to permit states to continue to impose premium lock-out periods only for families that have not paid outstanding premiums or enrollment fees,

and only up to a 90-day period. A 90-day premium lock-out maximum aligns with section 1201 of the Affordable Care Act, which prohibits periods without insurance exceeding 90 days for health plans and health insurance issuers offering group or individual coverage. We also specify that past due premiums or enrollment fees must be forgiven if a child has been subject to a lock-out period, regardless of length of the lock -out period. The majority of states with premium lock-out periods in place do not currently exceed 90 days and some states that have premium lock-out periods do not require the family to pay outstanding premiums in order to reenroll in the CHIP.

Under federal regulations, states have broad flexibility in determining how to notify and collect premiums and enrollment fees from families. We recognize that most states make efforts to facilitate payment of premiums and enrollment fees, easing the process for CHIP families. We invite comments from states on any alternative late payment policies to encourage families to make their CHIP premium payments in a timely manner in order to avoid gaps in coverage.

11. Premium Assistance (§435.1015)

Premium assistance programs use federal and state Medicaid and CHIP funds to help subsidize the purchase of coverage for Medicaid and CHIP-eligible individuals who have access to private coverage, but may need assistance in paying for their premiums. Premium assistance can provide a mechanism for facilitating the coordinated system of coverage between Medicaid, CHIP, and the Exchange in 2014. It will provide an option for states to assist families who wish to enroll in the same health plan when some family members are eligible for either Medicaid or CHIP while other family members obtain coverage on the Exchange with advance payments of the premium tax credit. Premium assistance provides an opportunity for state Medicaid and CHIP programs to offer coverage to such families through the same coverage source, even if supported by different payers. States can use federal and state Medicaid and CHIP funds to deliver Medicaid and CHIP coverage through the purchase of private health insurance through

plans in the individual market, which in 2014, would include QHPs available through the Exchange.

Premium assistance is authorized for group coverage in Medicaid under sections 1906 or 1906A of the Act, and in CHIP, under sections 2105(c)(3) or 2105(c)(10) of the Act. Based on authority in sections 1905(a) and 2105(c)(3) of the Act, we propose at §435.1015 also to authorize premium assistance programs to support enrollment of individuals eligible for Medicaid and CHIP in plans in the individual market, including enrollment in QHPs in the Exchange.

Thus, a state Medicaid or CHIP program could use existing premium assistance authority to purchase coverage for a Medicaid or CHIP-eligible individual through a QHP, while other family members would receive advance payment of the premium tax credit. However, APTC would not be provided for the Medicaid or CHIP-eligible family members. Premium assistance could help increase the likelihood that individuals moving from Exchange coverage into Medicaid or CHIP may remain in the same QHP in which they had been enrolled through the Exchange. We invite comments on how the state Medicaid and CHIP agency can coordinate with the Exchange to establish and simplify premium assistance arrangements and how these arrangements will be operationalized.

In the matter following section 1905(a)(29) of the Act, "medical assistance" is defined to include payment of part or all of the cost of "other insurance premiums for medical or any other type of remedial care or cost thereof." We interpret this provision to permit payment of FFP for premiums for individual health plans for Medicaid-eligible individuals, provided the state determines it cost-effective to do so, similar to the requirement for payment of premiums for enrollment in a group health plan under sections 1906, 1906A or 2105 of the Act.

Under section 1902(a)(25) of the Act, codified in subpart D of part 433 of the regulations, the insurer would be obligated to be primary payer relative to Medicaid for all health

care items and services for which the insurer is legally and contractually responsible under its insurance policy. The matter following section 1905(a)(29) of the Act does not limit the benefits or services to which an individual otherwise is eligible. Thus, Medicaid-eligible individuals enrolled in a private health plan would remain qualified for all benefits for which the individual is covered under the state plan, regardless of whether or not the state is providing payment for enrollment in the private plan, and a state opting to provide premium assistance support for enrollment in an individual health plan would have to provide covered benefits not covered under the private policy. In addition, the state would need to ensure that individuals do not incur cost sharing charges in excess of amounts imposed by the state under sections 1916, 1916A, or 2103(e) of the Act.

Under proposed §435.1015, states will be expected to demonstrate cost-effectiveness in the same manner as is required under the sections 1906, 1906A, 2105(c)(3), and 2105(c)(10) of the Act. We believe this is consistent with section 10203(b) of the Affordable Care Act, which aligned requirements for cost-effectiveness for premium assistance programs under the authorities of sections 1906, 1906A, 2105(c)(3), and 2105(c)(10), but was silent with respect to premium assistance under section 1905(a) authority.

To be "cost-effective" under proposed §435.1015, the cost of purchasing coverage under an individual health plan for a Medicaid-eligible individual in the private market, including coverage in a QHP in the Exchange, must be comparable to the cost of providing direct coverage under the state plan (or waiver of the state plan). We propose that the test for cost-effectiveness includes administrative expenditures and the costs of providing wraparound benefits for items and services otherwise covered under the Medicaid state plan.

In addition, under the sections 1906 and 1906A premium assistance authorities, states may claim FFP for payment of premiums for non-Medicaid-eligible family members if enrollment in a group health plan of such family members is necessary for the enrollment of the

Medicaid-eligible individual, as long as the cost-effectiveness test is met. We do not anticipate that such arrangements would be necessary to support enrollment of a Medicaid-eligible individual in a health plan in the individual market, and therefore do not include provision for payment of premiums for non-Medicaid-eligible family members under proposed §435.1015. However, we seek comments on this provision.

12. Electronic Submission of the Medicaid and CHIP State Plan (§§ 430.12, 457.50, and 457.60)

We are proposing to revise sections §§430.12, 457.50, and 457.60 to reflect our implementation of an automated transmission process for the Medicaid and CHIP business process. Historically, we have accepted state plan amendments on paper following paper-based templates. These are submitted to the CMS Regional Offices and Central office, and adjudicated using a manual transmission process, resulting in lengthy review times. Additionally, this process was not transparent to states or other stakeholders. To move to a more efficient and transparent business process, in consultation with states, we are developing the MACPro (Medicaid and CHIP Program) system to electronically receive and manage state plan amendments as well as other Medicaid and CHIP business documents. The proposed revisions direct states to use the automated format for submission of state plan amendments, replacing previous paper based documents, and gives states a period of time to make the transition to the new system with technical support from CMS.

13. Changes to Modified Adjusted Gross Income and MAGI Screen

a. Changes for Modified Adjusted Gross Income

We propose several revisions to the Medicaid eligibility final rule regarding the household composition of individuals whose financial eligibility is determined using the MAGI-based methodologies set forth at §435.603, which implement section 1902(e)(14) of the Act, as added by section 2002 of the Affordable Care Act.

First, in accordance with sections 1902(e)(14)(A) and 1943 of the Act and section 1413 of the Affordable Care Act, we intended in the March 23, 2012 Medicaid eligibility final rule to apply the definitions of "modified adjusted gross income" and "household income" in section 36B(d)(2) of the Internal Revenue Code of 1986 ("36B definitions") to treat stepparents the same as natural and adopted parents, and stepchildren and stepsiblings the same as biological and adopted children and siblings, for purposes of determining household composition and household income. However, whereas virtually everywhere that reference in §435.603 to "parents" is made, the Medicaid eligibility final rule explicitly refers to "natural, adopted or stepparents," we inadvertently did not include such reference in §435.603(f)(2)(ii), referring instead only to children claimed by one "parent" who are living with "both parents." We propose to remedy this technical error, and simultaneously further streamline the regulation text, by adding a definition of "parent" in paragraph (b) to include natural, adopted and stepparents, and to replace all references elsewhere throughout §435.603 to "natural, adopted or stepparents" with a reference to "parents," as newly defined. We propose adding a similar definition and to make similar streamlining revisions in the case of references in the Medicaid eligibility final rule to "natural, adopted and step children" and "natural, adopted, half or step siblings." We considered "half siblings" to be included within the meaning of natural and adopted siblings in the Medicaid eligibility final rule, but are including such siblings explicitly in the definition proposed here.

Second, section 1902(e)(14)(I) of the Act requires the application of a 5 percent disregard for purposes of determining the income eligibility of an individual for medical assistance whose eligibility is determined based on MAGI. In the Medicaid eligibility final rule, we defined household income in §435.603(d)(1) with certain exceptions as the sum of the MAGI-based income of every individual in the individual's household, minus an amount equivalent to 5 percentage points of the federal poverty level for the applicable family size. The result of this

disregard policy is that individuals determined for eligibility under MAGI have a 5 percent disregard applied to their income, when their eligibility under a particular eligibility category is being determined, and that disregard can impact the group for which such individual is found eligible.

For example, if the income standard for eligibility under section 1931 in a state were 90 percent of the FPL and a parent with 95 percent of the FPL who met the categorical requirements for coverage applied, the 5 percent disregard would apply to that parent resulting in eligibility for the section 1931 category. If the state had expanded coverage to the new adult group, such that the adult group covered parents with income greater than 90 percent of the FPL to 133 percent of the FPL, a parent with 95 percent FPL would still be determined eligible for the section 1931 category. This would impact the Federal Medical Assistance Percentage that the state could claim for this individual and could impact the benefits the individual received. As set forth in §433.10 of our Medicaid Eligibility proposed rule, the rate of federal financial participation is increased for newly eligible individuals, provided they are in the adult group. An individual cannot meet the definition of a newly eligible individual for whom the state may claim enhanced FMAP unless, at a minimum, that individual qualifies for eligibility in the adult group. It could also impact the benefits available to that parent, because states are required to provide benchmark benefits for individuals in the adult group.

Since the publication of our Medicaid eligibility final rule, we have considered an alternative interpretation for section 1902(e)(14)(I) of the Act. Section 1902(e)(14)(I) states that the 5 percent disregard should be applied, "for purposes of determining the income eligibility of an individual for medical assistance whose eligibility is determined based on the application of MAGI". Instead of applying the five percent disregard to determine eligibility for a particular eligibility category, we are proposing a policy under which the five percent disregard should be applied when its application affects eligibility on the basis of MAGI. Thus the five percent

disregard would be applied not when eligibility for any Medicaid eligibility group is being determined but, rather, when an applicant or beneficiary would otherwise be ineligible for any medical assistance (under any MAGI-based eligibility category in the program). The impact of this change would be that the five percent disregard would apply only to the highest income threshold under a MAGI-based group available for that person.

In the example above, the application of the five percent disregard to the 1931 group would be contingent on whether the section 1931 group was the highest income threshold available to that parent or caretaker relative in the Medicaid program. If so – for example, in a state that did not expand eligibility to the adult group – the five percent disregard would be applied, and the individual with household income equaling 95 percent FPL would be determined eligible for the 1931 group. If, in the example above, the state did expand eligibility to the new adult group, the five percent disregard would not be applied to the parent with income at 95 percent FPL, because the highest income standard for the parent would be the income standard for the new adult group (133 percent FPL), and the individual would be determined eligible for the adult group. If the parent met the definition of a newly eligible individual, the state could then claim the enhanced FMAP for this individual. The five percent disregard would, however, be applied to a parent with income at 138 percent of the FPL, because 133 percent FPL would be the highest eligibility category for which the parent could qualify in the Medicaid program. To implement this policy, we propose to delete the across-the-board application of the deduction of five percent FPL from the calculation of every household income in §435.603(d)(1) and to add a new sub paragraph §435.603(d)(4) to apply the five percent disregard only when determining an individual for the eligibility group with the highest income standard, using MAGI-based methodologies, under which the individual may be determined eligible.

Third, we propose to clarify the regulatory exception from application of MAGI-based financial methodologies for individuals needing long-term care services in paragraph (j)(4) of

§435.603 of the Medicaid eligibility final rule, because it could be interpreted in a manner to extend the reach of the exception beyond that intended either under section 1902(e)(14)(D)(iv) of the Act, as added by section 2002 of the Affordable Care Act, or the Medicaid eligibility final rule. As promulgated, paragraph (j)(4) could be interpreted to except from MAGI-based methods individuals requesting long-term care services that are covered under an eligibility group otherwise subject to MAGI-based methodologies, such as those for pregnant women and children at §§435.116 and 435.118, respectively. This was not our intention in the Medicaid eligibility final rule. Revisions to §435.603(j)(4) therefore are proposed to clarify that the exception from application of MAGI-based methods applies only in the case of individuals who request coverage for long-term care services and supports for the purpose of being evaluated for an eligibility group for which meeting a level-of-care need is a condition of eligibility or under which long-term care services not covered for individuals determined eligible using MAGI-based financial methods are covered. The exception does not apply to someone eligible using MAGI-based methodologies under a MAGI-based eligibility group which covers the needed long-term care services, simply because the individual requests such services.

We also are considering for comment, but have not included here, a couple other revisions to the regulations at §435.603 to address issues stakeholders have raised as a result of the Medicaid eligibility final rule. First, there are situations in which an individual is counted as part of two households for purposes of determining each household's Medicaid eligibility and that individual's entire income is counted as available to each household, when, in reality, only a portion of the individual's income may actually be available to each household. For example, we believe this could occur when one or both spouses in a married couple not filing jointly claims one or more tax dependents, when one or both members of an unmarried couple with a child in common have tax dependents of their own, and in some three-generation households, depending on the tax filing status of the household members. Based on the authority provided in

section 1902(e)(14)(H)(ii) of the Act, we are considering revisions to §435.603 to avoid these results. We are seeking comments on this and other situations in which this might occur, and on revisions that would address this issue.

b. MAGI Screen (§435.911)

Consistent with sections 1902(a)(4), (a)(8), (a)(10)(A), (a)(19), and (e)(14) and section 1943 of the Act, in §435.911, we established at §435.911 of the Medicaid eligibility final rule a simplified test for determining eligibility based on MAGI. To effectuate this test, we provided a definition of "applicable MAGI standard," which will be at least 133 percent of the FPL, but in some states, based on state-established standards, may be higher for pregnant women, children, or in a few states, parents and caretaker relatives. We propose two minor revisions to the definition of "applicable MAGI standard" at §435.911(b), and to extend use of the MAGI screen to elderly and disabled adults who may be eligible as a parent or caretaker relative based on MAGI, but who are not included in the MAGI screen established in the Medicaid eligibility final rule.

The applicable MAGI standard for parents and caretaker relatives should be the highest income standard which can be applied to determining eligibility for a parent or caretaker relative under any eligibility group using MAGI-based household income, as defined in §435.603 of the Medicaid eligibility final rule. Section 435.911(b)(1)(i) of the Medicaid eligibility final rule provides that this applicable MAGI standard is the higher of 133 percent FPL (the income standard for the new adult group at §435.119 of the Medicaid eligibility final rule) and the income standard established by the state for mandatory coverage of parents and caretaker relatives under section 1931(b) of the Act, implemented at §435.110 of the final Eligibility Rule. Because some states have expanded coverage to parents and caretaker relatives at higher income levels through the adoption of an optional group for parents and caretaker relatives under section 1902(a)(10)(A)(ii)(I) of the Act, implemented at §435.220 of this proposed rulemaking, the

income standard applied by the state to this optional group in accordance with proposed §435.220(c), if higher than both 133 percent FPL and the standard for coverage under §435.110, should serve as the applicable MAGI standard for parents and caretaker relatives. We propose revisions at §435.911(b)(1)(i), accordingly, to accurately reflect the applicable MAGI standard for parents and caretaker relatives. As provided at §435.911(b)(1)(iv) of the Medicaid eligibility final rule, if the state has adopted, and phased in coverage of parents and caretaker relatives under, the optional eligibility group for individuals with MAGI-based household income over 133 percent FPL, the applicable MAGI standard under paragraph (b)(1) will be the income standard adopted by the state for that optional eligibility group in accordance with §435.218(b)(1)(iv).

Paragraph (c)(1) of §435.911 of the Medicaid eligibility final rule excluded from the simplified MAGI screen all individuals who are excluded from the new adult group because they have attained at least age 65 or are entitled to or enrolled for Medicare. Such individuals may be eligible based on MAGI, however, if they also are a parent or caretaker relative or are pregnant. We therefore clarify at proposed §435.911(b)(2) that there generally is no applicable MAGI standard for individuals who have attained at least age 65 and individuals ages 19 – 64 who are entitled to or enrolled for Medicare, unless such individual also is pregnant or is a parent or caretaker relative. For such individuals, proposed §435.911(b)(2) defines the applicable MAGI standard, in the case of such individuals who are pregnant as the applicable MAGI standard established for pregnant women under paragraph (b)(1) and, for elderly or Medicare-eligible parents and caretaker relatives, the higher of the income standards established by the state under the mandatory and optional eligibility groups for parents and caretaker relatives.

14. Single State Agency – Delegation of eligibility determination to Exchanges (§§ 155.110, 431.10, and 431.11)

In the Medicaid Eligibility proposed rule, published on August 17, 2011 (76 FR 51148), we proposed to allow Medicaid agencies to delegate eligibility determinations to Exchanges that are public agencies authority to make Medicaid eligibility determinations as long as the single state Medicaid agency retained authority to issue policies, rules and regulations on program matters and to exercise discretion in the administration or supervision of the plan. We also noted that if Exchanges were established as non-governmental entities as allowed by the Affordable Care Act, the coordination provisions in the law may be more challenging and, for example, could require the co-location of Medicaid state workers at Exchanges or other accommodations to ensure coordination is accomplished. We solicited comment on approaches to accommodate the statutory option for a state to operate an Exchange through a private entity, including whether such entities should be permitted to conduct Medicaid eligibility determinations consistent with the law.

Based on comments we received to our proposal, in the Medicaid eligibility final rule, we permitted a broader delegation of Medicaid eligibility determinations that we initially proposed, permitting delegation of eligibility determinations to any Exchange, whether a governmental or non-governmental organizations, to promote coordination and ensure that Exchanges could make Medicaid eligibility determinations, even when non-governmental. We limited the eligibility determination authority of an Exchange operated by a non-governmental entity or that contracted with private entities to MAGI-based determinations only, provided that the single state agency retained its responsibilities for supervising the administration of the plan and for making the rules and regulations for administering the plan, and that it remained accountable for the proper administration of the program exercising appropriate control and oversight over any entity making final eligibility determinations on its behalf.

Several provisions of the Medicaid eligibility final rule were issued on an interim final basis. Though the single state agency provisions were not issued as interim final rules open for

comment, we received public comments on them because they were closely related to the interim final regulatory provision at §435.1200(c) that was subject to comment. That provision referred to treatment of individuals determined eligible for Medicaid by a final determination of another insurance affordability program. Numerous commenters requested that CMS reconsider our policy permitting delegation of eligibility determinations to nongovernmental entities. They expressed multiple concerns including their belief that determining Medicaid eligibility is an inherently governmental function that should not be delegated to a nongovernmental entity. Some argued that even with the stronger standards in the Medicaid eligibility final rule, Medicaid's oversight of Exchanges run by or contracting with private entities would be limited by the lack of a contractual relationship between the Medicaid agency and the private entity.

In light of these public comments, we are proposing to revert to the policy proposed in the Medicaid eligibility proposed rule, that state Medicaid agencies would be limited to delegating eligibility determinations to Exchanges that are government agencies maintaining personnel standards on a merit basis. For purposes of delegation, we would treat a public authority running an Exchange and employing merit system protection principles as a government agency such that delegation to it would be permitted. We would retain many of the provisions strengthening the control and oversight responsibilities of the single state agency. We seek comment to this proposed change regarding permissible delegations of final Medicaid eligibility determinations. In addition, we are seeking further comment regarding ways states can ensure a coordinated system by engaging non-profits and private contractors in the process of supporting Medicaid and the CHIP eligibility determinations while ensuring that any final Medicaid eligibility determination is made by a government agency. We believe this potential change is consistent with current state practices and plans.

Thus, we are proposing at 42 CFR 431.10 to delete the provision at (c)(3) added by the Medicaid eligibility final rule which provided that Exchanges operated as nongovernmental

entities as permitted under 45 CFR 155.110(c), or contracting with a private entity for eligibility services, as permitted under 1311(f)(3) of the Affordable Care Act and 45 CFR 155.110(a) are permitted to make final determinations of eligibility limited to determinations using MAGI-based methods as set forth in §435.603 of this subchapter. We propose instead to add explicit language to: implement 1902(a)(3) and (a)(5) of the Act by requiring the Medicaid agency remain responsible for determining eligibility for all individuals applying for or receiving benefits and for conducting fair hearings; consolidate §431.10(c)(1) and (c)(2) (regarding the other state or federal agencies to which the single state agency currently is permitted to delegate authority to determine Medicaid eligibility) into a new paragraph (c)(1)(i); and add an Exchange established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act to the list of permissible agencies. We further propose at §431.10(c)(2) to require that any entity to which such authority is delegated be a governmental agency which maintains personnel standards on a merit basis consistent with section 1902(a)(4) of the Act, which we add as a basis in §431.10(a)(1).

Consistent with the statutory authority at 1902(a)(5), we are retaining the requirements added in the Medicaid eligibility final rule which strengthened the controls and oversight of the single state agency, but as noted in section II.A of the preamble, we have streamlined and reorganized the text of those paragraphs in this proposed rulemaking. We believe that such strengthened controls are appropriate for a single state agency that delegates eligibility, even to another government agency. We are also proposing conforming changes to §431.10(d) regarding agreements with federal or state and local entities for eligibility determinations.

We note that because delegation will only be permitted to an Exchange to the extent that the eligibility determinations are made by a government agency maintaining personnel standards on a merit basis consistent with requirements set forth in section 1902(a)(4) of the Act, the single state agency will be allowed to delegate authority for an eligibility determination to

the Exchange, including an eligibility determination for MAGI-excepted individuals. Alternatively, the single state agency may arrange to have the Exchange screen for possible Medicaid eligibility for MAGI-excepted individuals as set forth in §435.911 and coordinate the transfer of the application to the Medicaid agency, as set forth in §435.1200. Because the single state agency may delegate eligibility determination authority for different populations to more than one agency (for example, to the Social Security Administration, the agency administering the state's program under title IV-A of the Act, and/or the Exchange), we further propose at §431.10(c)(1)(i) to require that the state plan reflect both the agency to which authority is delegated as well as the individuals whose eligibility can be determined by such delegee.

Finally, we are proposing to make changes to §431.11 regarding state organization. We are proposing to delete the requirement at §431.11(b) for the state plan to provide for a medical assistance unit within the Medicaid agency. Similarly, we are proposing to delete the requirement at §431.11(c), redesignated as §431.11(b), for the state plan to provide a description of the organization and functions of the medical assistance unit and an organization chart, as well as a description of the kinds and numbers of professional medical personnel and supporting staff used in the administration of the plan and their responsibilities. We believe that states should have maximum flexibility to organize themselves however they choose, but seek public comment on this proposal regarding any reasons we should retain this requirement. Finally, we are proposing conforming changes to §431.10(d), redesignated as §431.10(c) to delete the references to nongovernmental entities conducting eligibility determinations or Exchange contractors performing eligibility functions.

15. Medical Support and Payments (§§433.138, 433.145, 433.147, 433.148, 433.152 and 435.610)

Section 1912 of the Act requires, as a condition of eligibility for Medicaid, that parents seeking coverage cooperate with the state in establishing paternity and in obtaining medical

support and payments. These requirements can be waived for good cause. While parents can be denied Medicaid eligibility or terminated from coverage for failure to cooperate, children cannot be denied Medicaid eligibility or terminated from coverage due to a parent's failure to do so. State Medicaid agencies must enter into agreements with the child support agency in the state, or another appropriate state agency, to effectuate section 1912 of the Act and the collection of medical child support. Section 1912 of the Act is implemented at §433.135 through §433.154 and §435.610 of the current regulations.

We propose to revise of §433.148(a)(2) and §435.610(a)(2) to provide that, consistent with the practice in many states today, individuals (unless exempt per existing regulations) must agree to cooperate in establishing paternity and obtaining medical support at application, but that enforcement of actual measures to cooperate happen following enrollment in coverage. As discussed in the Medicaid eligibility final rule, states must align the eligibility rules for all insurance affordability programs to the maximum extent possible, to achieve a highly coordinated and streamlined eligibility and enrollment system. Important to the achievement of such a system is that individuals are enrolled in coverage in as close to real time as possible. However, in some cases today, enrollment in Medicaid for parents who are subject to these cooperation requirements is often delayed until the parent can show that he or she has cooperated with the child support agency, undermining the goal of real-time processing of applications. Cooperation with establishing paternity and obtaining medical support is not required for purposes of eligibility for other insurance affordability programs. Because all insurance affordability programs will use the same streamlined application and eligibility determinations and enrollment will be coordinated, an eligibility determination for Medicaid should not be delayed by the cooperation requirements. Further, in states which authorize the Exchange to make Medicaid eligibility determinations, it would not be realistic to expect the Exchange to implement this Medicaid requirement prior to making a determination. Post-enrollment enforcement allows the Exchange to make Medicaid

determinations, facilitates coordination among the programs, and ensures individuals have access to coverage in a timely manner.

Under the proposed revisions, individuals must attest on the application that they agree to cooperate with the state in establishing paternity and obtaining medical support payments. However, the state should not wait until otherwise eligible individuals actually begin cooperating before finalizing the eligibility determination and furnishing benefits. If the individual does not cooperate, consistent with the requirements described in §433.147 of the regulations, the Medicaid agency must take action to terminate eligibility in accordance with part 431 subpart E (relating to notice and fair hearing rights). In addition to the change described above, we are making technical corrections to §§433.138, 433.145, 433.147 and 435.610 to update references to pregnant women eligibility under section 1902(a)(10)(A)(i) of the Act to a reference to §435.116, as promulgated in the Medicaid eligibility final rule, and to update or eliminate references to verification regulations in subpart J of part 435 of the regulations which were eliminated or revised in the Medicaid eligibility final rule. We also propose to delete §433.152(b)(1) because 45 CFR part 306 no longer exists. Section 433.147(c)(1) is revised and §433.147(d) is deleted to eliminate references to factors applicable to waiving the cooperation requirement contained in 45 CFR part 232 because part 232 of 45 CFR was removed from the regulations following with the passage of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA). Finally, we propose to delete §435.610(c) as no longer relevant since the effective dates referenced were at least 25 years ago.

16. Conversion of Federal Minimum Income Standards for Section 1931 (§§435.110 and 435.116)

Section 1902(e)(14)(A) and (E) of the Act, as added by section 2002 of the Affordable Care Act, provides for the conversion of the income standards in effect in the state prior to the Affordable Care Act to thresholds that are not less than the levels that applied on the date of

enactment. In our Medicaid Eligibility proposed rule published in the **Federal Register** on August 17, 2011, we proposed to retain the minimum income standards specified in federal statute for each eligibility group, while giving states flexibility to set new standards using Modified Adjusted Gross Income (MAGI) at a level that would take into account a state's current rules regarding how income is counted. We discussed that we considered whether or not states should convert the federal minimum income standards prescribed in statute – for example, the minimum standard for pregnant women and children specified in section 1902(l) and for parents and other caretaker relatives in section 1931(b) of the Act—to a MAGI-equivalent minimum income standard based on the income disregards currently used by the state. We explained that while doing so could result in maintaining eligibility for individuals who might otherwise lose Medicaid due to the elimination of income exclusions and disregards under MAGI, if a state were to reduce its income standard to the minimum permitted, it also would result in different minimum income eligibility standards being applied across states and reduce the amount of eligibility simplification that could be achieved. We finalized the policy in our Medicaid eligibility final rule, and further noted that the effect of the statute's requirement to raise the statutory minimum standards for children ages 6 to 18 to 133 percent of the FPL under section 1902(a)(10)(A)(i)(VII) of the Act was to align all age groups of children at 133 percent of the FPL, along with adults under age 65, and that a policy that required conversion of federal minimums for younger children would defeat such alignment and result in children in the same family potentially being eligible for different insurance affordability programs depending on their age.

Since the publication of the Medicaid eligibility final rule, the Supreme Court decided in National Federation of Independent Business v. Sebelius, ____ U.S. _____; 132 S. Ct. 2566; 183 L.Ed. 2d 450 (2012) that the Secretary does not have authority to penalize a state for not

adopting the new adult group, resulting in uncertainty regarding whether the new adult group coverage will be available for parents and other caretaker relatives with income at or below 133 percent FPL who do not meet the financial eligibility requirements of section 1931 of the Act. We also issued a Solicitation of Public Input on the Conversion of Net Income Standards to Equivalent MAGI Standards (Solicitation) and received numerous comments on this issue. Commenters noted that in states that do not expand coverage to the new adult group, and who reduce coverage for parents to statutory federal minimum thresholds (the AFDC standard in effect as of May 1, 1988 for the applicable family size), eligibility for coverage for these parents could be restricted if minimum eligibility thresholds are not converted. They noted that if the federal minimum thresholds are less than 100 percent of the FPL, parents in a state that does not expand may not even have the opportunity to receive an advance payment of a premium tax credit to purchase coverage on the Exchange.

In light of the comments received to our Solicitation, we are proposing to require conversion of the federal minimum income standard for section 1931 of the Act. Although the statute is silent with respect to conversion of federal minimum income standards, the intent of sections 1902(e)(14)(A) and (E) of the Act is to ensure that in the aggregate individuals that would have been eligible under Medicaid rules in effect prior to the Affordable Care Act remain eligible once the new MAGI-based methodologies go into effect. Our proposal to direct conversion of the federal minimum standard for section 1931 would implement the conversion requirements in the statute more consistently, which is particularly important in light of the voluntary nature of the low income adult expansion under the Supreme Court's decision. In addition, because pregnancy benefits for pregnant women under §435.116(d)(4)(i) are tied to the same May 1, 1988 AFDC income standard for the applicable family size, we are proposing that this income limit should also be converted. However, for the reasons stated in the Medicaid Eligibility proposed and final rules, we are not revisiting our policy with respect to the

conversion of federal minimum income standards and limits for all other eligibility groups and covered services, which are not required to be converted under the Medicaid eligibility final rule.

II. Essential Health Benefits in Alternative Benefit Plans

A. Background

Beginning in 2014, all non-grandfathered health insurance coverage[1] in the individual and small group markets, Medicaid benchmark and benchmark-equivalent plans (now also known as Alternative Benefit Plans), and Basic Health Programs (if applicable) will cover essential health benefits (EHBs), which include items and services in 10 statutory benefit categories, such as hospitalization, prescription drugs, and maternity and newborn care, and are equal in scope to a typical employer health plan.

B. Provision of the Proposed Rule: Part 440—Medicaid Program; State Flexibility for Medicaid Benefit Packages

1. Subpart C—Benchmark Benefit and Benchmark-Equivalent Coverage

a. Conforming Changes to Medicaid to Align with Essential Health Benefits

Section 1937 of the Act provides states with the flexibility to amend their Medicaid state plans to provide for the use of benefit packages other than the standard Medicaid state plan benefit package offered in that state, for certain populations as defined by the state. These "Alternative Benefit Plans" are based on benchmark or benchmark-equivalent packages. There are four benchmark packages described in section 1937 of the Act:

- The benefit package provided by the Federal Employees Health Insurance Benefit plan (FEHB) Standard Blue Cross/Blue Shield Preferred Provider Option;

[1] For more information on status as a grandfathered health plans under the Affordable Care Act, please see Interim Final Rule, "Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act." Available at: http://cciio.cms.gov/resources/regulations/index.html#gp.

- State employee health coverage that is offered and generally available to state employees;
- The health insurance plan offered through the Health Maintenance Organization (HMO) with the largest insured commercial non-Medicaid enrollment in the state; and
- Secretary-approved coverage, which is a benefit package the Secretary has determined to provide coverage appropriate to meet the needs of the population provided that coverage.

Under the Deficit Reduction Act of 2005 (DRA) (Pub. L. 109-171, enacted on February 8, 2006), benchmark-equivalent coverage is provided when the aggregate actuarial value of the proposed benefit package is at least actuarially equivalent to the coverage provided by one of the benefit packages described above, for the identified Medicaid population to which it will be offered. Section 1937 of the Act further provides that certain categories of benefits must be provided in any benchmark-equivalent plan, and other categories of benefits must include "substantial actuarial value" compared to the benchmark package.

Section 2001(c) of the Affordable Care Act modified the benefit provisions of section 1937. Specifically, section 2001(c) added mental health benefits and prescription drug coverage to the list of benefits that must be included in benchmark-equivalent coverage; required the inclusion of Essential Health Benefits (EHBs) beginning in 2014; and directed that section 1937 benefit plans that include medical/surgical benefits and mental health and/or substance use disorder benefits comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).

In addition, section 2001(a)(1) of the Affordable Care Act established a new adult eligibility group for low-income adults age 19 to 64 effective January 1, 2014. States that implement this new eligibility group shall provide medical assistance for that group through an Alternative Benefit Plan (which must include EHBs as of the same date) subject to the requirements of section 1937 of the Act.

Finally, section 2004 of the Affordable Care Act, as amended by section 10201(a) of the Affordable Care Act, added a new optional eligibility group for "former foster care children" under age 26 that provides that these individuals will not be included in the new adult eligibility group and exempts these individuals from mandatory enrollment in an Alternative Benefit Plan. Section 2303(c) of the Affordable Care Act provides that medical assistance to individuals described in 1905(a)(4)(C) of the Act (individuals of child bearing age), through enrollment in an Alternative Benefit Plan, shall include family planning services and supplies.

This proposed rule revises current Medicaid regulations to conform to these statutory changes; provides further interpretation of how EHBs apply to Medicaid; and makes other changes to further simplify, clarify and align regulatory requirements between Medicaid and the private insurance market, where appropriate. We issued a State Medicaid Director letter on the above topics on November 20, 2012.

We propose to make the following changes in Medicaid regulations to implement new statutory or regulatory requirements flowing from these provisions. These proposed changes are meant to codify statutory requirements or to align Medicaid regulations to the policies discussed earlier in this proposed rule. The proposed changes to the regulation are as follows:

- Amend §440.305 by re-designating the current paragraph (d) as §440.386 and to revise sections (a) and (b) to address the addition of the new adult eligibility group as being eligible for coverage under an Alternative Benefit Plan.

- Amend §440.315(h) to codify the provision that, while a new eligibility group, former foster care children are statutorily exempt from mandatory enrollment in an Alternative Benefit Plan.

- Add to §440.335 Benchmark-equivalent health benefits coverage, new paragraphs (b)(7) and (b)(8) to include benchmark-equivalent health benefits coverage for prescription drugs and mental health benefits in accordance with section 2001(c) of the Affordable Care Act.

- Add paragraph (b) to §440.345 to codify section 2303(c) of the Affordable Care Act to provide that Alternative Benefit Plan coverage provided to individuals described in section 1905(a)(4)(C) of the Act (individuals of child bearing age), include family planning services and supplies.

- Add a new paragraph §440.345(c), to incorporate section 2001(c)(6) of the Affordable Care Act.

- In §440.345(d), codify the requirement that Alternative Benefit Plans provide EHBs and include all updates or modifications made thereafter by the Secretary to the definition of EHBs.

- In §440.345(e), allow Alternative Benefit Plans that are determined to include EHBs as of January 1, 2014 to remain effective through December 31, 2015 without need for updating, at the state's option. We will consult with states and stakeholders and evaluate the process to determine how often states would need to update these types of Alternative Benefit Plans after that date.

- Add a new §440.347 titled "Essential Health Benefits" to incorporate section 2001(c)(5) of the Affordable Care Act.

- In §440.347(e), codify section 1302(b)(4) of the Affordable Care Act provides that benefit design cannot discriminate "on the basis of an individual's age, expected length of life, or of an individual's present or predicted disability, degree of medical dependency, or quality of life or other health conditions". Benefit design non-discrimination policies do not prevent states from exercising Section 1937 targeting criteria.

b. Modifications in applying the provisions of this proposed rule to Medicaid

As reflected above, the definition and coverage provisions for EHBs described in the "Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation" proposed rule published on November 20, 2012, apply to Medicaid except in specific circumstances. The

conforming changes we propose to existing regulations, together with the statutory and regulatory requirements already existing in title XIX and the **Federal Register**, form the basis for how the Medicaid program will implement these benefit options.

Given the intersection of section 1937 of the Act and the provisions in the Affordable Care Act relating to EHBs, there would be a two-step process in Medicaid for designing Alternative Benefit Plans. The Affordable Care Act modified section 1937 of the Act to implement two standards for minimum coverage provision; not only must EHBs as defined by the Secretary be provided, but all requirements of section 1937 of the Act continue to apply. States will first select a coverage option from the choices found in section 1937 of the Act. The next step is determining whether that coverage option is also one of the base-benchmark plan options identified by the Secretary as an option for defining EHBs.

- If so, the standards for the provision of coverage, including EHBs, would be met, as long as all EHB categories are covered, including through any necessary supplementation of missing EHB categories.

- If not, states will additionally select one of the base-benchmark plan options identified as defining EHBs. This means that states will compare the coverage between the 1937 of the Act coverage option and the selected base-benchmark plan for defining EHBs and if the 1937 of the Act coverage is missing a category of EHB, supplement accordingly.

In keeping with section 1937 of the Act's waiver of comparability, states may choose to target populations for receipt of specialized benefit packages, allowing for different Alternative Benefit Plans to apply to different populations. Furthermore, we propose at a new §440.347(c) that a state has the option to select a different base-benchmark plan to establish EHBs for each Alternative Benefit Plan.

As described in the "Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation" proposed rule published on November 20, 2012, the state has the opportunity to

define habilitative benefits using a transitional approach in which states may either define the habilitative services category or leave it to issuers. In §156.115 (a)(4), it was proposed that if the EHB-benchmark plan does not include coverage for habilitative services and the state does not determine habilitative benefits, a health insurance issuer must select from two options: (1) provide parity by covering habilitative services benefits that are similar in scope, amount, and duration to benefits covered for rehabilitative services; or (2) decide which habilitative services to cover and report on that coverage to HHS. The issuer only has to supplement habilitative services when there are no habilitative services offered in in the base benchmark plan or the state has not exercised its option to define habilitative services under §156.110(f). We propose that states define this benefit for Medicaid. We are seeking comments regarding whether the state defined habilitative benefit definition for the Exchanges should apply to Medicaid or whether states should be allowed to separately define habilitative services for Medicaid. We are soliciting comments on the option for states to fully define the benefit and various approaches for doing so and whether the habilitative benefit should be offered in parity with the rehabilitative benefit as was contemplated in the "Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation" proposed rule published on November 20, 2012. Thus, we reserved §440.347(d) to incorporate an approach after comments are received for states to define the Medicaid habilitative services EHB.

We also note two areas where states have questioned application of proposed rules for EHBs with respect to Medicaid, and wish to clarify. Neither requires any regulatory change. First, for Medicaid, medically necessary services, including pediatric oral and vision services, must be provided to eligible individuals under the age of 21 under the Medicaid Early Periodic Screening, Diagnostic and Testing (EPSDT) benefit. As a result, any limitation relating to pediatric services that may apply in a base benchmark plan in the context of the individual or small group market does not apply to Medicaid. Second, section 1927 of the Act sets forth

requirements for covered outpatient drugs, whereby drug manufacturers must pay statutorily-defined rebates to the states through the Medicaid drug rebate program. In return, any state that provides payment for drugs must cover all covered outpatient drugs, which may include appropriate limitations on amount, duration, and scope, for the drug manufacturers that participate in the Medicaid drug rebate program. Section 1927 of the Act also applies to Alternative Benefit Plans. Consistent with the current law, states have the flexibility within those statutory and regulatory constructs to adopt prior authorization and other utilization control measures, as well as policies that promote the use of generic drugs.

All other provisions under title XIX of the Act apply, unless, as spelled out in section 1937 of the Act, a state can satisfactorily demonstrate that implementing such other provisions would be directly contrary to their ability to implement Alternative Benefit Plans under section 1937 of the Act.

We also clarify that preventive services as established in November 20, 2012 Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation apply. Specifically, the proposed rule requires that all EHB Benchmark plans cover a broad range of preventive services including: "A" or "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by Institute of Medicine (IOM).Title XIX premium and cost-sharing provisions apply to preventive services.

2. Other Changes to Simplify, Modernize and Clarify Medicaid Benchmark Requirements and Make Technical Corrections to Coverage Requirements

We also propose to make certain changes to the regulations in order to promote simplification and clarification where needed, and provide some additional flexibilities to states

regarding benefit options. The proposed changes to the regulations are as follows:

- In §440.130, conform our regulatory definition relating to who can provide preventive services with the statute. Our current regulation, §440.130, states that preventive services must be provided by a physician or licensed practitioner. This is not in alignment with the statutory provision at 1905(a)(13) of the Act that defines "services…recommended by a physician or other licensed practitioner of healing arts within the scope of their practice under State law".

- Add §440.386 to allow states greater flexibility when required to publish public notice. We propose modifying the public notice requirement for Alternative Benefit Plans to require that such notice be given prior to implementing a state plan amendment (SPA) when the new Alternative Benefit Plan provides individuals with a benefit package equal to or enhanced beyond the state's approved state plan, or adds additional services to an existing Alternative Benefit Plan. We also propose to retain the requirement to publish public notice prior to submitting a SPA that establishes an Alternative Benefit Plan which provides less benefits than the state's approved state plan, which includes or increases cost sharing of any type, or which amends an approved Alternative Benefit Plan by adding cost sharing or reducing benefits.

- Revise §440.315(f) by modifying the definition of "medically frail" to specifically include individuals with disabling mental disorders (to include children with serious emotional disturbances and adults with serious mental illness), individuals with serious and complex medical conditions, individuals with a physical, intellectual or developmental disability that significantly impairs their ability to perform one or more activities of daily living, or individuals with a disability determination, based on Social Security criteria, or in states that apply more restrictive criteria than the Supplemental Security Income (SSI) program, as the state plan criteria. We are clarifying this language to ensure that all people with disabilities are included in the medically frail definition. We are specifically soliciting comments on whether individuals with a substance use disorder should be added to the definition of "medically frail" and therefore

exempted from mandatory enrollment in an Alternative Benefit Plan.

- Amend §440.330(d) by replacing the phrase "benefits within the scope of the categories available under a benchmark coverage package" with "benefits of the type, which are covered in one or more of section 1937 of the Act benchmark coverage packages described in §440.330(a) through (c)" in order to clarify that Secretary-approved coverage may include benefits of the type which are covered in 1 or more of the section 1937 of the Act commercial coverage packages. We are also clarifying §440.335(c) and §440.360 in the same way.

- Revise §440.330(d), §440.335(c) and §440.360 to indicate that such coverage may, at state option, include the benefits described in sections 1915(i), 1915(j), 1915(k) and 1945 of the Act, and any other Medicaid state plan benefits enacted under title XIX, or benefits available under base benchmark plans described in section 45 CFR §156.100, along with the benefits described in 1905(a) of the Act. When including these benefits, the state must comply with all provisions of these sections. And, consistent with the provisions of sections 1902(k)(1) and 1903(i)(36) of the Act, we provide that the coverage for individuals eligible only through section 1902(a)(10)(A)(i)(VIII) is limited to benchmark or benchmark equivalent coverage, except that we propose that exemptions from mandatory enrollment in such coverage would still be applicable for individuals eligible on that basis consistent with our understanding of congressional intent.

III. Eligibility Appeals and Other Provisions Related to Eligibility and Enrollment for Exchanges

A. Background

This proposed rule supplements and, in some respects, amends provisions originally published as the March 27, 2012 rule titled Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers ("Exchange Final Rule") (77 FR 18310). The provisions contained in this proposed rule

encompass key functions of Exchanges related to eligibility and enrollment. Given that states have relied on the provisions of the Exchange final rule to plan their systems for 2014, we intend whenever possible, when we finalize this rule, to provide some type of transition for such states, and welcome comments on its design and the length of the transition.

1. Legislative Overview

Section 1311(b) and section 1321(b) of the Affordable Care Act provide that each state has the opportunity to establish an Exchange that: (1) facilitates the purchase of insurance coverage by qualified individuals through qualified health plans (QHPs); (2) assists qualified employers in the enrollment of their employees in QHPs; and (3) meets other standards specified in the Affordable Care Act. Section 1311(k) of the Affordable Care Act specifies that Exchanges may not establish rules that conflict with or prevent the application of regulations promulgated by the Secretary. Section 1311(d) of the Affordable Care Act describes the minimum functions of an Exchange, including the certification of QHPs.

Section 1321 of the Affordable Care Act discusses state flexibility in the operation and enforcement of Exchanges and related policies. Section 1321(c)(1) directs the Secretary to establish and operate such Exchanges within states that either: (1) do not elect to establish an Exchange, or (2) as determined by the Secretary on or before January 1, 2013, will not have an Exchange operable by January 1, 2014. Section 1321(a) also provides broad authority for the Secretary to establish standards and regulations to implement the statutory standards related to Exchanges, QHPs, and other standards of title I of the Affordable Care Act.

Section 1401 of the Affordable Care Act creates new section 36B of the Internal Revenue Code (the Code), which provides for a premium tax credit for eligible individuals who enroll in a QHP through an Exchange. Section 1402 of the Affordable Care Act establishes provisions to reduce the cost-sharing obligation of certain eligible individuals enrolled in a QHP through an Exchange, including standards for determining whether Indians are eligible for certain categories

of cost-sharing reductions.

Under section 1411 of the Affordable Care Act, the Secretary is directed to establish a program for determining whether an individual meets the eligibility standards for Exchange participation, advance payments of the premium tax credit, cost-sharing reductions, and exemptions from the shared responsibility payment under section 5000A of the Code.

Sections 1412 and 1413 of the Affordable Care Act and section 1943 of the Social Security Act (the Act), as added by section 2201 of the Affordable Care Act, contain additional provisions regarding eligibility for advance payments of the premium tax credit and cost-sharing reductions, as well as provisions regarding simplification and coordination of eligibility determinations and enrollment with other health programs.

Unless otherwise specified, the provisions in this proposed rule related to the establishment of minimum functions of an Exchange are based on the general authority of the Secretary under section 1321(a)(1) of the Affordable Care Act.

2. Stakeholder Consultation and Input

HHS has consulted with interested stakeholders on policies related to the eligibility provisions and Exchange functions. HHS held a number of listening sessions with consumers, providers, employers, health plans, and state representatives to gather public input, and released several documents for public review and comment. HHS also released a bulletin that outlined our intended regulatory approach to verifying access to employer-sponsored coverage and sought public comment on the specific approaches.

Finally, HHS consulted with stakeholders through regular meetings with the National Association of Insurance Commissioners (NAIC), regular contact with states through the Exchange grant process, Medicaid consultation, and meetings with tribal leaders and representatives, health insurance issuers, trade groups, consumer advocates, employers, and other interested parties.

We considered all of these comments as we developed the policies in this proposed rule.

3. Structure of the Proposed Rule

The proposed amendments to 45 CFR part 155 in this rule propose standards related to eligibility appeals, notices, and other eligibility standards for insurance affordability programs to facilitate a streamlined process for eligibility for enrollment in a QHP through the Exchange and insurance affordability programs.

Amendments to 45 CFR part 155 subpart A revise existing definitions and propose new definitions.

A technical correction is made to 45 CFR part 155 subpart B.

Amendments to 45 CFR part 155 subpart C provide for standards related to application counselors and authorized representatives.

Amendments to 45 CFR part 155 subpart D propose standards related to eligibility determinations for enrollment in a QHP and for insurance affordability programs.

Amendments to 45 CFR part 155 subpart E propose standards related to enrollment-related transactions, special enrollment periods, and terminations.

The addition of 45 CFR part 155 subpart F proposes standards related to the eligibility appeals process.

Amendments to 45 CFR part 155 subpart H propose standards related to eligibility appeals related to the SHOP.

4. Alignment with Related Rules and Published Information

As outlined previously in this proposed rule, this rule proposes Medicaid provisions associated with the eligibility changes under the Affordable Care Act of 2010. We refer to these provisions throughout this section as the "Medicaid proposed provisions."

B. Provisions of the Proposed Regulations: Part 155—Exchange Establishment Standards and Other Related Standards Under the Affordable Care Act

Throughout this proposed rule, we propose technical corrections to regulation sections in part 155 to replace references to section 36B of the Code with the corresponding sections to the Department of Treasury's final rule, Health Insurance Premium Tax Credit (26 CFR 1.36B), published in the May 23, 2012 **Federal Register** (77 FR 30377).

1. Definitions (§155.20)

We propose to make a technical correction to the definition of the term "advance payments of the premium tax credit." We note that advance payments of the premium tax credit means the advance payment of the tax credits authorized by section 36B of the Code as well as its implementing regulations. We also propose to remove the reference to section 1402 of the Affordable Care Act, as it concerns cost-sharing reductions as opposed to the premium tax credit.

We propose to make a technical correction to the term "application filer." We clarify that our previous inclusion of an authorized representative in the definition refers to the authorized representative of an applicant. We also cite to the applicable Treasury regulation instead of section 36B of the Code.

We propose to define the term "catastrophic plan" by reference to section 1302(e) of the Affordable Care Act.

We propose to amend the term "lawfully present." As discussed in preamble to 45 CFR 155.20, the definition of "lawfully present" included in the Exchange final rule is intended to align with the definition of "lawfully residing" as used in section 214 of the Children's Health Insurance Program Reauthorization Act (Pub. L. 111-3, enacted on February 4, 2009) (CHIPRA). As 42 CFR 435.4 of the Medicaid proposed provisions implements the CHIPRA definition by defining the term, "lawfully present", we are proposing to adjust our definition to define "lawfully present" through reference to the Medicaid proposed provisions. The definition used in 42 CFR 435.4 of the Medicaid proposed provisions is substantially the same as the

definition used in 45 CFR 152.2, with minor modifications, described in more detail in the preamble associated with 42 CFR §§435.4, 435.406, and 457.320 of the Medicaid proposed provisions. Generally, these modifications are made in order to achieve greater operational simplification and to align with current policies, including a clarification regarding eligibility for individuals with deferred action under the Deferred Action for Childhood Arrivals (DACA) process.

2. Approval of a State Exchange (§155.105)

We propose to make a technical correction in paragraph (b)(2) to cite to the applicable Treasury regulation instead of section 36B of the Code.

3. Functions of an Exchange (§155.200)

We propose to revise paragraph (a) to clarify that the Exchange must also perform the minimum functions described in subpart F.

4. Consumer Assistance Tools and Programs of an Exchange (§155.205)

We propose to split paragraph (d) into paragraphs (d)(1) and (d)(2), and revise the text to clarify that prior to providing the consumer assistance specified in paragraph (d)(1) of this section, an individual must be trained regarding QHP options, insurance affordability programs, eligibility, and benefits rules and regulations governing all insurance affordability programs operated in the state, as implemented in the state. This is consistent with proposed §155.225(b)(2), and is designed to ensure that all types of assistance provided by the Exchange are provided by individuals who are appropriately trained, in order to ensure quality.

5. Certified Application Counselors (§155.225)

Section 1413 of the Affordable Care Act directs the Secretary to establish, subject to minimum requirements, a streamlined enrollment system for QHPs and all insurance affordability programs. State Medicaid and CHIP agencies have a long history of offering application assistance programs through which application counselors have had a key role in

promoting enrollment for low-income individuals seeking coverage, and we believe that making such assistance available for the Exchange will be critical to achieving a high rate of enrollment. Accordingly, the proposed regulation seeks to ensure that application counselors will also be available in the Exchange to help individuals and employees apply for enrollment in a QHP and for insurance affordability programs by adding §155.225 to establish the standards for Exchange certification of such application counselors. This language specifies that each Exchange will establish an application counselor program. The proposed standards closely track those for Medicaid application counselors so that the training can be streamlined.

In essence, application counselors will provide the same core application assistance service that is also available directly through the Exchange, as well as through Navigators and licensed agents and brokers; the distinction between these entities is that application counselors are not funded through the Exchange, through grants or directly, or licensed by states as agents or brokers. We believe that this separate class of application counselors is important to ensure that skilled application assistance is available from entities like community health centers and community-based organizations that may not fit in to the other categories. We are proposing a certification process so that individuals and employees will have assurance of the quality and privacy and security of the assistance available through these certified application counselors understanding that individuals may receive some level of informal assistance from family members and others who are not officially certified by the Exchange. We are proposing that certified application counselors would have a relationship with the Exchange so that they could officially support the process while ensuring the privacy and security of personal information. Given the overlap in the scope of responsibilities between application counselors, Navigators, agents and brokers, and other entities that provide help to consumers, we believe a state can develop a single set of core training materials that can be utilized by Navigators, agents and brokers, and application counselors. Additionally, we plan to make selected federal training and

support materials available that can be used by states, without the need to develop their own, to the extent that the state uses the model application established by HHS.

In paragraph (a), we propose that staff and volunteers of both Exchange-designated organizations and organizations designated by state Medicaid and CHIP agencies as it is defined in proposed §435.908 will be certified by the Exchange to act as application counselors, subject to the conditions in paragraphs (b) and (c). The Exchange will certify employees and volunteers of organizations as application counselors, which may include health care providers and entities, as well as community-based organizations, among other organizations. The designation of organizations by state Medicaid and CHIP agencies is subject to proposed §435.908.

We propose that certified application counselors: (1) Provide information to individuals and employees on insurance affordability programs and coverage options; (2) assist individuals and employees in applying for coverage in a QHP through the Exchange and for insurance affordability programs; and (3) help facilitate enrollment in QHPs and insurance affordability programs. We acknowledge that certified application counselors will not be able to sign the application or make any attestations on behalf of the individual. In contrast, we propose in §155.227 that an authorized representative can perform that function.

In paragraph (b), we propose standards for certification of individuals seeking to become application counselors. These standards will serve to ensure that application counselors will have the training and skills necessary to provide reliable assistance to consumers, that they disclose to the Exchange and applicant any financial or other relationships (either of the application counselor personally or of the sponsoring organization), that they will comply with the confidentiality requirements that apply to the data they will access in their role as application counselors, including section 6103 of the Internal Revenue Code and section 1902(a)(7) of the Act. Accordingly, we propose that the Exchange will certify as an application counselor any individual who: registers with Exchange; is trained prior to providing application assistance;

complies with applicable authentication and data security standards, and with the Exchange's privacy and security standards adopted consistent with 45 CFR 155.260; provides application assistance in the best interest of applicants; complies with any applicable state law related to application counselors, including state law related to conflicts of interests; provides information with reasonable accommodations for those with disabilities, if providing in-person assistance; and enters into an agreement with the Exchange. We seek comment on whether the Exchange should have the authority to create additional standards for certification or otherwise limit eligibility of certified application counselors beyond what is proposed here.

In paragraph (c) we provide that the Exchange will establish procedures to withdraw certification from individual application counselors, or from all application counselors associated with a particular organization, when it finds noncompliance with the terms and conditions of the application counselor agreement.

In paragraph (d), we propose that the Exchange establish procedures that ensure that applicants are informed of the functions and responsibilities of certified application counselors and provide authorization for the disclosure of his or her information to an application counselor prior to a counselor helping the applicant with submitting an application.

In paragraph (e), we propose that certified application counselors may not impose any charge on applicants for application assistance in order to support access for low-income individuals.

6. Authorized Representatives (§155.227)

Under 45 CFR 155.405(c)(1), the Exchange must accept applications from application filers which includes authorized representatives acting on behalf of an applicant. The proposed rules for authorized representatives for Exchanges closely track those for Medicaid. We propose to add a new §155.227 establishing minimum requirements for the designation of authorized representatives who may act on an individual's or employee's behalf.

In §155.227(a), we propose that, subject to applicable privacy and security requirements, the Exchange must permit individuals and employees to designate an individual or organization to act on that individual or employee's behalf, or may have such a representative through operation of state law (for example, through a legal guardianship arrangement). The Exchange must not restrict the option to designate an authorized representative to only certain groups of individuals or employees. We propose the Exchange ensures the authorized representative agrees to maintain, or be legally bound to maintain, the confidentiality of any information regarding the individual or employee provided by the Exchange, and that authorized representatives adhere to applicable authentication and data security standards. Additionally, we propose the Exchange ensures the authorized representative is responsible for fulfilling all responsibilities encompassed within the scope of the authorized representation, as described in this section, to the same extent as the individual he or she represents.

In §155.227(b), we propose the times during which the Exchange must permit an individual or employee may choose to designate an authorized representative. We intend that the single, streamlined application described in 45 CFR 155.405 will provide applicants the opportunity to designate an authorized representative and will collect the information necessary for such representative to enter into any associated agreements with the Exchange as part of the application process, and any alternative application developed by a state under 45 CFR 155.405(b) must do so as well. Individuals and employees who do not designate an authorized representative on their applications will subsequently be able to do so through electronic, paper formats and other modalities as described in 45 CFR 155.405(c)(2). Legal documentation of authority to act on behalf of an individual under state law, such as a court order establishing legal guardianship or a power of attorney, may serve in the place of the individual or employee's designation. The option to submit such documentation is intended to enable these applicants to have authorized representation without requiring duplicate authorization.

In §155.227(c), we propose that the Exchange must permit an individual to authorize a representative to -- (1) Sign the application on the individual's behalf; (2) submit an update or respond to a redetermination for the individual; (3) receive copies of the individual's notices and other communications from the Exchange; and (4) act on behalf of the individual in all other matters with the Exchange. Unlike a certified application counselor, the authorized representative has the ability to sign the application and make attestations on behalf of an individual.

In §155.227(d), we propose that the Exchange must permit an individual or employee to change or withdraw their authorization at any time. The authorized representative also may withdraw his or her representation by notifying the Exchange and the individual.

In §155.227(e), we propose that an authorized representative acting as either a staff member or volunteer of an organization and the organization itself must sign an agreement meeting the requirements in §155.225(b) of this part. While important in instances where an authorized representative is a member or volunteer of an organization, we believe that the protections afforded by the agreement are not logical in cases where an authorized representative is not acting on behalf of an organization. For example, a friend or family member who is authorized to represent an applicant would not be legally obliged to keep the applicant or enrollee's eligibility status confidential. We seek comments on applying the protections in paragraph (e) to authorized representatives more broadly.

In §155.227(f), we propose that the Exchange require authorized representatives to comply with any applicable state and federal laws concerning conflicts of interest and confidentiality of information.

In §155.227(g),we propose that designation of an authorized representative must be in writing including a signature or through another legally binding format and be accepted through all of the modalities described in 45 CFR 155.405(c) of this part.

7. General standards for Exchange notices (§155.230)

We propose to make a technical correction in paragraph (a) to clarify that the general standards for notices apply to all notices sent by the Exchange to individuals or employers. The goal of this change is to eliminate any confusion that may have resulted from the multiple categories of individuals, employees, and employers that were previously listed.

We also propose to revise paragraph (a) by redesignating paragraph (a)(1) as paragraph (a)(4) and redesignating paragraph (a)(2) as paragraph (a)(5). We revise redesignated (a)(2) to change "; and" to "." We propose to add new paragraph (a)(1) to indicate that any notice required to be sent by the Exchange to individuals or employers must be written and include an explanation of the action that is reflected in the notice, including the effective date of the action, and we propose to add new paragraph (a)(2) to require the notice to include any factual findings relevant to the action. We revise paragraph (a)(3) to clarify that the notice must include the citation to, or identification of, the relevant regulations that supports the action.

We propose to add paragraph (d) to allow the Exchange to provide notices either through standard mail, or if an individual or employer elects, electronically, provided that standards for use of electronic notices are met as set forth in §435.918, which contains a parallel provision. These standards ensure that individuals have the ability to control their preferences regarding how they receive notices; additionally, since notices will include personally identifiable information, these standards ensure that proper safeguards for the generation and distribution of notices are met. Providing an option for individuals and employers to receive notices electronically allows the Exchange to leverage available technology to reduce administrative costs and improve communication. This provision is discussed further in the preamble to §435.918. We note that the notice standards described in this section apply to notices required throughout 45 CFR part 155, including notices sent by the SHOP Exchange. We propose that the standards specifically described under proposed paragraph (d) do not apply to the SHOP

Exchange, because of the distinct nature of the relationship between the SHOP Exchange, employers, and employees. However, we also considered adopting an alternative approach whereby we would propose the same standard for the SHOP Exchange that we propose adopting for the individual market Exchange under paragraph (d), except that the SHOP Exchange would have more flexibility to adopt an all-electronic approach. We note that we expect that the SHOP Exchange may rely more heavily on electronic notices than the individual market Exchange. We seek comment on the approach we have proposed, and whether we should adopt the alternative approach.

8. Definitions and general standards for eligibility determinations (§155.300)

We propose to make a technical correction to remove the definition of "adoption taxpayer identification number" from paragraph (a), as it will not be used in the income verification process for advance payments of the premium tax credit and cost-sharing reductions, in accordance with proposed rules issued by the Secretary of the Treasury at 77 FR 25381.

We propose to make a technical correction to the definition of, "minimum value", to add "employer-sponsored" before the words "plan meets the," replace the word "requirements" with "standards" and cite to applicable Treasury regulations instead of section 36B of the Code. We also propose corrections to the definition of "modified adjusted gross income" and "qualifying coverage in an eligible employer-sponsored plan" to cite to the applicable Treasury regulation implementing section 36B of the Code.

9. Options for conducting eligibility determinations (§155.302)

In §155.302, we propose to amend paragraphs (a)(1), (b)(4), and (5). We note that this section is currently an interim final rule (77 FR 18451-52). With our proposals below, we intend to modify the interim final rule without finalizing it at this time.

We propose to make a technical correction in paragraph (a)(1) to align the language regarding the Exchange's ability to make eligibility determinations for Medicaid and CHIP with

language proposed in §431.10(c)(2), which specifies that Medicaid eligibility determinations may only be made by a government agency that maintains personnel standards on a merit basis.

We propose to amend paragraph (b)(4)(i)(A), adding language which provides that the withdrawal opportunity is not applicable in cases in which the Exchange has assessed that the applicant is potentially eligible for Medicaid based on factors other than MAGI, in accordance with 45 CFR 155.345(b). In this situation, the application will already be sent to Medicaid for a full determination that includes a determination based on criteria identified in 45 CFR 155.305(c) and (d) and other eligibility criteria not generally considered by an Exchange, such as disability. Therefore, withdrawal of the application in this instance is not applicable. We also propose that an individual's application not be considered withdrawn if the individual appeals his or her eligibility determination for advance payments of the premium tax credit or cost-sharing reductions and the Exchange appeals entity finds that the individual is potentially eligible for Medicaid or CHIP. The added language preserves an individual's right to a Medicaid or CHIP eligibility determination based on the initial date of application, as well as any appeal rights related to that determination.

We propose to amend paragraph (b)(5) to specify that the Exchange also will adhere to the appeals decision for Medicaid or CHIP made by the state Medicaid or CHIP agency, or the appeals entity for such program. The previous language only specified that the Exchange adhere to the initial eligibility determination for Medicaid or CHIP made by the state Medicaid or CHIP agency.

10. Eligibility standards (§155.305)

We propose to amend paragraph (a)(3) to add paragraph (a)(3)(v) concerning the eligibility standards for residency for enrollment in a QHP through the Exchange. We propose to specify that the Exchange may not deny or terminate an individual's eligibility for enrollment in a QHP through the Exchange if the individual meets the standards in paragraph (a)(3) but for a

temporary absence from the service area of the Exchange and the individual intends to return when the purpose of the absence has been accomplished, unless another Exchange verifies that the individual meets the residency standard of such Exchange. This proposal is designed to align the Exchange eligibility standards regarding residency with the Medicaid eligibility standards described in 42 CFR 435.403(j)(3). Both this provision and the parallel provision in 42 CFR 435.403(j)(3) are designed to ensure that an individual is not ruled ineligible during a period of temporary absence, which could create significant issues with respect to access to health care, as well as administrative burden associated with termination and reenrollment.

We propose to make technical corrections in paragraphs (f)(1), (f)(2), and (f)(5) to cite to the applicable Treasury regulation instead of section 36B of the Code.

We propose to amend paragraph (f)(3) to clarify that advance payments of the premium tax credit and cost-sharing reductions are available on behalf of a tax filer only if one or more applicants for whom the tax filer attests that he or she expects to claim a personal exemption deduction for the benefit year, including the tax filer and his or her spouse, is enrolled in a QHP, that is not a catastrophic plan, through the Exchange. This proposal aligns with the definition of QHP as provided in section 36B of the Code.

We propose to add paragraph (h) to outline the eligibility standards for enrollment through the Exchange in a QHP that is a catastrophic plan, as specified in section 1302(e) of the Affordable Care Act. We note that premium tax credits are not available to support enrollment in a catastrophic plan. In paragraph (h)(1), we propose to add language that an Exchange will determine a qualified individual eligible for enrollment through the Exchange in a QHP that is a catastrophic plan if he or she has not attained the age of 30 before the beginning of the plan year, in accordance with section 1302(e)(2)(A) of the Affordable Care Act. In paragraph (h)(2), we propose to add language specifying that the Exchange will determine a qualified individual eligible for enrollment through the Exchange in a QHP that is a catastrophic plan if he or she has

a certification that he or she is exempt from the shared responsibility payment under section 5000A of the Code based on a lack of affordable coverage or hardship. These standards reflect that the Exchange will only make eligibility determinations for enrollment through the Exchange in a QHP that is a catastrophic plan, as opposed to enrollment in catastrophic plans outside of the Exchange. The eligibility standards for exemptions under section 5000A of the Code will be discussed in future regulations.

11. Eligibility process (§155.310)

In accordance with section 1411(e)(4)(B)(iii) of the Affordable Care Act, section 155.310(h) specifies that the Exchange shall provide a notice to an employer if one of the employer's employees has been determined eligible for advance payments of the premium tax credit or cost-sharing reductions. Sections 1411(e)(4)(B)(iii) and 1411(f)(2) of the Affordable Care Act establish a system of notice to employers and an employer appeal when an employee's eligibility for advance payments of the premium tax credit is based on either the employer's decision not to offer minimum essential coverage to that employee or the plan sponsored by the employer does not meet the minimum value standard or is unaffordable.

Section 4980H of the Code limits the employer's liability for payment under that provision when the employer offers coverage to one or more full-time employees who are "certified to the employer under section 1411" as having enrolled in a QHP through the Exchange and for whom an applicable premium tax credit or cost-sharing reduction is allowed or paid. We propose to add new paragraph (i) regarding a certification program pursuant to the Secretary's program for determining eligibility for advance payments of the premium tax credit and cost-sharing reductions in accordance with section 1411(a) of the Affordable Care Act. This certification program is distinct from the notification specified in section 1411(e)(4)(B)(iii) and paragraph (h).

In new §155.310(i), we propose that the certification to the employer will consist of methods adopted by the Secretary of Treasury as part of the determination of potential employer liability under section 4980H of the Code. In this manner, the certification program will address not only individuals on whose behalf advance payments of the premium tax credit and cost-sharing reductions are provided, but also individuals claiming the premium tax credit only on their tax returns. We welcome comments on this proposal.

We also propose to combine previous paragraphs (i) and (i)(1) into new paragraph (j). We propose to amend paragraph (j) in order to align with proposed revised language in §155.335, which specifies that the Exchange will redetermine eligibility on an annual basis for all qualified individuals, not only enrollees. This is discussed further in the preamble associated with §155.335(a). We propose to remove the previous paragraph (i)(2), as it addressed situations in which a qualified individual did not select a plan before the date on which his or her eligibility would have been redetermined as a part of the annual redetermination process. Since the proposed change to §155.335(a) specifies that all qualified individuals will be redetermined on an annual basis, including paragraph (i)(2) in redesignated paragraph (j) would be unnecessary.

12. Verification process related to eligibility for enrollment in a QHP through the Exchange (§155.315)

We propose a technical correction in paragraph (b)(2) to clarify that the procedures specified for situations in which the Exchange is unable to validate an individual's Social Security number through the Social Security Administration (SSA) also address situations in which SSA indicates an individual is deceased.

In paragraph (f), we propose to clarify the circumstances that will trigger the inconsistency process described in paragraphs (f)(1) and (2). We clarify that when electronic data are required but data on an individual that is relevant to the eligibility determination is not contained in the electronic data source, the Exchange will follow procedures in paragraphs (f)(1)

and (2). Additionally, if electronic data are required but it is not reasonably expected that such data sources will be available within two days of the initial attempt to reach the data source, we clarify that the Exchange will follow procedures in paragraphs (f)(1) and (2), if applicable. We propose this change to clarify that if the Exchange is unable to reach a required electronic data source upon initial attempts, the Exchange may continue to attempt to reach this electronic data source prior to providing an eligibility determination. While we expect that in the majority of cases, such information will be available the next day (for example, when data sources are unavailable very late at night), we include an extra day just to ensure that inconsistency processes are not triggered unnecessarily in order to minimize confusion for individuals and administrative burden for the Exchange. This proposal will ensure that the Exchange completes all possible electronic verifications after the two-day period before requesting additional information from an individual.

We propose to revise paragraph (f)(4), which addresses eligibility for enrollment in a QHP and for advance payments of the premium tax credit and cost-sharing reductions, to clarify that the Exchange will determine eligibility during the period of time described in paragraph (f)(1) of this section based on the information provided by the applicant along with any information that has been verified. Paragraph (f)(1) describes the period during which the Exchange is required to make a reasonable effort to identify and address the causes of an inconsistency including through typographical or other clerical errors, such as by contacting the application filer to confirm the accuracy of the information submitted by the application filer. This effort to resolve the inconsistency without documentation is required by section 1411(c)(3) of the Affordable Care Act, referencing section 1902(ee)(1)(B)(i) of the Act, and section 1411(c)(4)(A)(i) of the Affordable Care Act. We also clarify that we expect that contact made with the individual to resolve typographical or other clerical errors under paragraph (f)(1) will occur primarily in a real-time fashion through the dynamic online application or through the call

center as an application is submitted via phone. Therefore, we expect that the initial eligibility determination provided to the individual who is otherwise eligible but for whom inconsistencies are outstanding, will occur, for the most part, after typographical and clerical errors have been addressed. Lastly, we note that to the extent that the effort in paragraph (f)(1) is unsuccessful, existing paragraph (f)(2)(ii) specifies that the Exchange will maintain the eligibility determination during the 90-day period that is provided for an individual to provide satisfactory documentation or otherwise resolve an inconsistency.

We propose to add paragraph (j) concerning the verification process related to eligibility for enrollment through the Exchange in a QHP that is a catastrophic plan. As noted above, we propose to add language at §155.305(h) to establish the eligibility standards for enrollment through the Exchange in a QHP that is a catastrophic plan; paragraph (j) provides the corresponding Exchange verification procedures. In paragraph (j)(1), we propose to add language concerning the verification of the applicant's age. We propose two options for this verification. First, the Exchange may accept the applicant's attestation of age without further verification, unless information provided by the applicant is not reasonably compatible with other information previously provided by the individual or otherwise available to the Exchange. Second, the Exchange may examine available electronic data sources that have been approved by HHS for this purpose, based on evidence showing that such data sources are sufficiently current and accurate, and minimize administrative costs and burdens.

In paragraph (j)(2), we propose to add language specifying that the Exchange will verify that an applicant for enrollment through the Exchange in a QHP that is a catastrophic plan based on an exemption from the shared responsibility payment under section 5000A of the Code due to lack of affordable coverage or hardship has a certificate of such an exemption issued by an Exchange. We anticipate that this will be accomplished either through use of the Exchange's records, if the exemption was issued by that Exchange, or through verification of paper

documentation if the certificate was issued by a different Exchange. We also note in paragraph (j)(3) that in the event that the Exchange is unable to verify information necessary to determine an applicant's eligibility for enrollment through the Exchange in a QHP that is a catastrophic plan, the Exchange will follow the inconsistency process described in §155.315(f), except for §155.315(f)(4), which does not apply to the eligibility criteria for enrollment through the Exchange in a QHP that is a catastrophic plan. That is, an applicant will not be determined eligible through the Exchange in a QHP that is a catastrophic plan until verification of necessary information can be completed. We welcome comments on these provisions.

13. Verifications related to eligibility for insurance affordability programs (§155.320)

We propose to make a technical correction in paragraph (c)(1)(i) to change "tax return data" to "data regarding annual household income." We amend paragraph (c)(1)(i)(A) to include data regarding Social Security benefits as defined in 26 CFR 1.36B-1(e)(2)(iii). This reflects the legislative change made by Pub. L. No. 112-56 concerning the treatment of Social Security benefits related to MAGI. Specifically, in some situations, IRS will be unable to calculate MAGI for certain relevant taxpayers who have nontaxable Social Security benefits; the proposed new language in this paragraph reflects the need to obtain this data from the Social Security Administration to support the verification of annual household income. Section 155.320(c)(1)(i) establishes a system through which the Exchange contacts HHS and HHS secures the annual household income data available from IRS and Social Security Administration, for purposes of determining MAGI. We anticipate that the Social Security Administration will provide the full amount of Social Security benefits to HHS for disclosure to the Exchange as part of the verification process described in §155.320(c).

We propose to make a technical correction in paragraph (c)(1)(i)(A) to remove the language concerning an adoption taxpayer identification number, as it will not be used in the income verification process for advance payments of the premium tax credit and cost-sharing

reductions, in accordance with proposed rules issued by the Secretary of the Treasury at 77 FR 25381. We also propose to make a technical correction to cite to the applicable Treasury regulation instead of section 36B of the Code.

We propose to make a technical correction in paragraph (c)(1)(ii) to add the word "calculated" prior to "in accordance with 42 CFR 435.603(d)." We also propose to make a technical correction to cite to the applicable Treasury regulation instead of section 36B of the Code.

We propose to make a technical correction in paragraph (c)(3)(i)(D) by adding the word "the" after the first word, "If," in the paragraph such that it now reads "If the Exchange finds that…."

We propose to add paragraph (c)(3)(i)(E) to specify that the Exchange verify that neither advance payments of the premium tax credit nor cost-sharing reductions are already being provided on behalf of an individual, which is an important program integrity measure. As proposed, the language specifies that the Exchange will use information from HHS to support this verification.

We propose to make a technical correction to paragraph (c)(3)(ii)(A) to reflect the amendment made to paragraph (c)(1)(i)(A) of this section, reflecting the legislative change made by Pub. L. No. 112-56 concerning the treatment of Social Security benefits related to MAGI.

We propose to amend paragraph (c)(3)(iii) to clarify procedures that the Exchange will follow when an applicant attests that his or her annual household income has increased or is reasonably expected to increase from the annual household income computed based on available data. In general, the proposed language does not modify the general approach of accepting an applicant's attestation to projected annual household income when it exceeds the amount indicated by available data regarding annual household income; however, it provides additional detail regarding the Exchange's procedures to ensure that such an attestation does not

dramatically understate income, by checking whether available data regarding current household income indicates that his or her projected annual household income may exceed his or her attestation by a significant amount, and if so, proceeding in accordance with paragraphs (f)(1) through (4) of §155.315 to verify the applicant's attestation. We have developed these procedures in conjunction with states to clarify an existing provision such that it can be effectively implemented, and solicit comment regarding whether there are ways to further simplify the process.

We propose to amend paragraph (c)(3)(iii)(A) to reflect the proposed amendments to paragraphs (c)(3)(iii)(B) and (C), which are described in more detail below.

We are proposing to redesignate current paragraph (c)(3)(iii)(B) as paragraph (c)(3)(iii)(C). In new paragraph (c)(3)(iii)(B), we propose that if the applicant attests that a tax filer's annual household income has increased or is reasonably expected to increase from annual household income computed based on available data, but available data regarding current household income indicates that his or her projected annual household income may exceed his or her attestation by a significant amount, the Exchange will proceed in accordance with paragraphs (f)(1) through (4) of §155.315 to verify the applicant's attestation. In newly redesignated paragraph (c)(3)(iii)(C), we propose to add to the prior language of paragraph (c)(3)(iii)(B) such that if other information provided by the application filer (for example, an attestation of current monthly income) indicates that the applicant's projected annual household income is in excess of his or her attestation by a significant amount, the Exchange will utilize current income data to verify the applicant's attestation. In the event that such data are not available or is not reasonably compatible with the applicant's attestation, we propose that the Exchange follow procedures described in paragraphs (f)(1) through (f)(4) of §155.315 to verify the attestation. Together, these procedures are designed to provide a common-sense approach to ensuring that the Exchange will complete additional verification for the very limited number of situations in

which an attestation to projected annual household income that is in excess of annual household income data may still be understated by a significant margin.

We propose to amend paragraph (c)(3)(vi) to provide more specificity regarding when electronic data other than tax data and information regarding Social Security benefits is sufficient to verify an applicant's attestation of annual income. Based on consultation with a number of states, we propose revisions to paragraphs (c)(3)(vi)(A) through (F), and add paragraph (c)(3)(vi)(G) to better describe the process that the Exchange will follow in situations in which the applicant's attestation to projected annual household income, as described in paragraph (c)(3)(ii)(B) of this section, is greater than ten percent below the annual household income computed in accordance with paragraph (c)(3)(ii)(A), or if data described in paragraph (c)(1)(i) of this section is unavailable when comparing an applicant's attestation to annualized data from MAGI-based income sources. With the proposed text, the process follows the same standards that the Exchange will use for comparisons with annual income data, which is why states recommended that we take this approach.

Specifically, we propose that the Exchange consider an applicant's attestation to projected annual household income as verified if it is no more than ten percent below annual household income computed from the data sources described in paragraph (c)(3)(vi)(A) of this section, which are annualized data from MAGI-based income sources and any other electronic data sources approved by HHS, respectively. We believe that this is a reasonable threshold given that it is the same threshold as is used in comparing an applicant's attestation to tax data and information regarding Social Security benefits, which are the primary sources of verification specified in paragraph (c)(3) of this section.

Consistent with the final rule, the Exchange will follow the procedures specified in §155.315(f)(1) through (4) for situations in which an applicant's attestation is more than ten percent below annual household income computed from the data sources described in paragraph

(c)(3)(vi)(A) of this section, or when such data are unavailable. Taken together, these proposed clarifications are designed to provide operational specificity to states that are developing Exchanges. We solicit comment regarding whether we can provide additional clarification to further support the design of state systems. We propose to make a technical correction to paragraph (c)(3)(vii) to remove the word "this" prior to "paragraph (c)(3)," and clarify that we are referring to paragraph (c)(3) of this section. We also propose to make a technical correction to cite to the applicable Treasury regulation instead of section 36B of the Code.

We propose to make a technical correction in paragraph (c)(3)(viii) to cite to the applicable Treasury regulation instead of section 36B of the Code.

We propose to consolidate paragraphs (d) and (e), currently entitled "Verification related to enrollment in an eligible employer-sponsored plan" and "Verification related to eligibility for qualifying coverage in an eligible employer-sponsored plan," respectively, into new paragraph (d). The new proposed paragraph (d) sets forth the rules for verifying enrollment in an eligible employer-sponsored plan and eligibility for qualifying coverage in an eligible employer-sponsored plan. The consolidated paragraph, entitled "Verifications related to enrollment in an eligible employer-sponsored plan and eligibility for qualifying coverage in an eligible employer-sponsored plan" streamlines the process, provides further detail regarding the standards for these verification procedures, and proposes a process under which an Exchange may rely on HHS to complete this verification.

HHS performed a comprehensive search to identify potential electronic resources to support a real-time verification of eligibility for qualifying coverage in an eligible employer-sponsored plan, which involves verifying whether an individual has access to health coverage through his or her employer, as well as information regarding the employee's share of the premium amount for and minimum value of that health coverage. We explored existing data resources at the state and federal level, and in the private sector, in an effort to pursue a strategy

that minimizes burden for Exchanges, employers, and consumers. HHS also published a Request for Information on April 30, 2012, requesting input from potential vendors who might be able to produce a resource that comprehensively supports this verification (https://www.fbo.gov/?s=opportunity&mode=form&id=96c35957187f37da97e40d2c384b666c&tab=core&_cview=0). Based on the results of these efforts, HHS determined that a comprehensive data set that could assist in verification for the entire Exchange population will not be available from a single source by October 1, 2013. Information released to employees under section 18B of the Fair Labor Standards Act and the through the Summary of Benefits and Coverage document specified in section 2715 of the Public Health Service Act is not sufficient because, among other issues, it only requires the disclosure of information regarding whether the employer provides minimum essential coverage, and not whether such coverage is affordable as defined in 26 CFR 1.36B-2(c)(3)(v). Further, the information in these disclosures is reported directly to employees and not reported to the Exchange. Additionally, the limited information such as the Employer Identification Number and aggregate cost of coverage in an eligible employer-sponsored plan that will be available on the W-2, and reporting required under sections 6055 and 6056 of the Code, is retrospective in nature. Since the Exchange must verify whether the applicant reasonably expects to have access to qualifying coverage prospectively at the time of open enrollment, this information is not useful. Reporting under sections 6055 and 6056 of the Code will not begin until 2015, although it is anticipated that this reporting could greatly contribute to the integrity of employer verification in the future. In response to the April 26, 2012 bulletin outlining an interim solution for Exchanges to meet the standards for verifying eligibility for qualifying coverage in an eligible employer-sponsored plan (http://cciio.cms.gov/resources/files/exc-verification-guidance-vach.pdf), commenters also suggested that HHS seek information to support this verification from insurers. However, insurers are not typically privy to the relevant data elements needed as part of the eligibility

determination for advance payments of premium tax credit. The Administration continues to examine ways, both administrative and legislative, by which employer reporting under the Affordable Care Act can be streamlined both in timeframe and in the number of elements to prevent inefficient or duplicative reporting. We seek comment on policies to promote these goals.

We identified a limited number of data sources to verify enrollment in or eligibility for employer-sponsored coverage at the federal level. HHS will make available data regarding eligibility and enrollment for coverage under the Federal Employee Health Benefit Program (FEHBP) for verification purposes through HHS. This data will only assist in verification for federal employees and their dependents. We also propose that an Exchange use SHOP records to verify enrollment in an eligible employer-sponsored plan and eligibility for qualifying coverage in an eligible employer-sponsored plan.

We propose to amend §155.320(d) consistent with the interim strategy outlined in the April 26, 2012 bulletin, with one modification that is described in the preamble associated with paragraph (d)(3)(iii). It is anticipated that the strategy proposed below will evolve as additional data and data sources will become available; for this reason, this verification strategy is subject to change in later years. The approach for plan years 2016 and beyond will depend on the identification and or development of one or more data sources to promote a more comprehensive and automated pre-enrollment verification process.

In paragraph (d), we propose the process for verification related to enrollment in an eligible employer-sponsored plan and eligibility for qualifying coverage in an eligible employer-sponsored plan. In paragraph (d)(1), we propose that the Exchange must verify whether an applicant reasonably expects to be enrolled in an eligible employer-sponsored plan or is eligible for qualifying coverage in an eligible employer-sponsored plan for the benefit year for which coverage is requested. In the following paragraphs, we detail a series of data sources that we

propose the Exchange will check as a component of this verification, the verification procedures for situations in which data is unavailable or inconsistent with an individual's attestation, and an option for the Exchange to rely on HHS to complete this verification.

In paragraph (d)(2), we propose the data sources the Exchange will use to verify access to employer-sponsored coverage. We also note that consistent with proposed paragraph (d)(4), an Exchange can elect to have HHS conduct the entire verification process described under paragraph (d), including obtaining data from the proposed data sources. In paragraph (d)(2)(i), we propose that the Exchange will obtain data about enrollment in an eligible employer-sponsored plan and eligibility for qualifying coverage in an eligible employer-sponsored plan from any electronic data sources that are available to the Exchange and which have been approved by HHS for this purpose based on evidence showing that such data sources are sufficiently current, accurate, and minimize administrative burden. This provision is designed to support the use of state-based data sources that exist or may be developed by states (for example, those that support CHIP premium assistance programs).

In paragraph (d)(2)(ii), we specify that the Exchange must obtain any available data regarding enrollment in an eligible employer-sponsored plan or eligibility for qualifying coverage in an eligible employer-sponsored plan based on federal employment by transmitting identifying information specified by HHS to HHS. HHS will then match this request to data maintained by the Office of Personnel Management regarding the Federal Employees Health Benefits Program. Further, in paragraph (d)(2)(iii), we propose that the Exchange must obtain data from the SHOP that operates in the state in which the Exchange is operating, which will provide a readily available source of information with minimal administrative burden.

Finally, in paragraph (d)(2)(iv), we specify that the Exchange must obtain any available data regarding the employment of an applicant and the members of his or her household, as defined in 26 CFR 1.36B-1(d), from any electronic data sources that are available to the

Exchange and have been approved by HHS for this purpose, based on evidence showing that such data sources are sufficiently current, accurate, and minimize administrative burden. We anticipate that data sources in this category will include state quarterly wage data, as well as commercial sources of current wage data, which we intend to approve for these purposes. These existing data sources provide information regarding employment, which is a basic element of verifying information provided by an individual regarding access to employer-sponsored coverage. Although these data sources, which are also used by the Exchange to verify household income, will only reflect whether an individual is employed and with which employer, and not whether the employer provides health insurance or the characteristics of such health insurance, they can be used as prompts or helpful hints to support accurate attestations, or identify situations in which employment information is inconsistent with an applicant's attestation. Since these data sources do not directly address enrollment in an eligible employer-sponsored plan or eligibility for qualifying coverage in an eligible employer-sponsored plan, we seek comment on whether they should only be used as a point of information for applicants, and not as a point of comparison for the purposes of identifying inconsistencies as part of the verification described in this paragraph.

We believe that the connection to the data sources described in paragraph (d)(2) will be minimally burdensome for Exchanges, considering that data under paragraph (d)(2)(i) will not be available for the first year of operations unless an Exchange proposes an acceptable data source to HHS; data under paragraph (d)(2)(ii) will be available through HHS; data under paragraph (d)(2)(iii) will be internal to the Exchange; and data under paragraph (d)(2)(iv) will already be used to verify current income. We solicit comment regarding the feasibility of making the necessary connections by October 1, 2013, and whether alternative approaches should be considered for the first year of operations.

In paragraph (d)(3), we propose procedures for verifying enrollment in an eligible

employer-sponsored plan and eligibility for qualifying coverage in an eligible employer-sponsored plan. In paragraph (d)(3)(i), we propose that except as specified in paragraphs (d)(3)(ii) or (iii) of this section, the Exchange must accept an applicant's attestation regarding the verification specified in paragraph (d) without further verification.

In paragraph (d)(3)(ii), we propose, if an applicant's attestation is not reasonably compatible with the information specified in paragraphs (d)(2)(i) through (d)(2)(iii) of this section, other information provided by the application filer, or other information in the records of the Exchange, the Exchange will follow the procedures specified in §155.315(f) of this subpart, which are used throughout this subpart to address inconsistencies. We note that this process involves providing a period of time for an applicant to provide satisfactory documentation, or otherwise resolve the inconsistency, and we solicit comment regarding whether we should take this approach of relying on the applicant, or instead request information directly from his or her employer.

Finally, we propose in paragraph (d)(3)(iii) that if the Exchange does not have any of the information specified in paragraphs (d)(2)(i) through (d)(2)(iii) for an applicant, and either does not have the information specified in paragraph (d)(2)(iv) for an applicant or an applicant's attestation is not reasonably compatible with the information specified in (d)(2)(iv) of this section, the Exchange must select a statistically significant random sample of such applicants and follow the procedures proposed in paragraphs (d)(3)(iii)(A) through (d)(3)(iii)(G), which are described below, and are generally consistent with the process specified in §155.315(f), with modifications to ensure that it suits this verification. The April 26, 2012 bulletin discussed initiating and conducting this review later in the benefit year; however, we have proposed that the Exchange initiate the review at the point of eligibility determination and conduct it within the 90-day period that is also used for other verification requests, in order to allow the Exchange to reuse components of the inconsistency process to the maximum extent possible, streamline

communications with applicants, and ensure that any changes that need to be made are made as quickly as possible after initial enrollment, and not significantly later in the year after advance payment of the premium tax credit and CSR have been provided for many months. We also note that to the extent that multiple members of a single tax household are selected for the sample, we expect that the Exchange will consolidate the activities under this section, including communications with employers.

We propose to handle inconsistencies with the information specified in paragraph (d)(2)(iv) through the sampling process, rather than through the procedures specified in §155.315(f) because the information specified in paragraph (d)(2)(iv) only reflects employment, and does not provide comprehensive information regarding enrollment in an eligible employer-sponsored plan or eligibility for qualifying coverage in an eligible employer-sponsored plan; further, we anticipate that information that is available under paragraph (d)(2)(iv) may be somewhat dated. We solicit comments regarding whether this is a suitable approach, whether the information in paragraph (d)(2)(iv) should only be used as a point of information for applicants and not as a point of comparison for the purposes of identifying inconsistencies as part of the verification described in this paragraph, or if we should treat any inconsistency regarding an employer as an inconsistency that must be resolved in order to continue eligibility.

We believe that requesting and reviewing documentation for a statistically significant random sample of individuals for whom no inconsistencies are identified based on the data in paragraph (d)(2) is appropriate to ensure program integrity while minimizing administrative burden, and also may inform future verification approaches. We request comments on a methodology by which an Exchange could generate a statistically significant sample of applicants and whether there are ways to focus the sample on individuals who are most likely to have access to affordable, minimum value coverage. By using a process that maintains the policy and operational framework of the inconsistency process for these individuals, we leverage

existing Exchange processes and also provide an option for advance payments of the premium tax credit and cost-sharing reductions during the period in which the Exchange is working to obtain additional information.

First, in paragraph (d)(3)(iii)(A), we propose that the Exchange will provide notice to an applicant who is selected as part of the sample indicating that the Exchange will be contacting any employer identified on the application for the applicant and the members of his or her household, as defined in 26 CFR 1.36B-1(d) to verify whether the applicant is enrolled in an eligible employer-sponsored plan or is eligible for qualifying coverage in an eligible employer-sponsored plan for the benefit year for which coverage is requested. We expect that this notice will not specify a time period for the completion of these activities, and will notify the applicant that the Exchange will provide an additional communication only if information gathered will change anything regarding his or her eligibility. We seek comment on ways the Exchange may communicate this sampling process to consumers with the intention of minimizing confusion.

In paragraph (d)(3)(iii)(B), we propose that the Exchange proceed with all other elements of eligibility determination using the applicant's attestation, and provide eligibility for enrollment in a QHP to the extent that an applicant is otherwise qualified. And in paragraph (d)(3)(iii)(C), we propose that the Exchange ensure that advance payments of the premium tax credit and cost-sharing reductions are provided on behalf of an applicant who is otherwise qualified for such payments and reductions, as described in §155.305 of this subpart, if the tax filer attests to the Exchange that he or she understands that any advance payments of the premium tax credit paid on his or her behalf are subject to reconciliation. The provisions in paragraphs (d)(3)(iii)(B) and (C) are identical to those in §155.315(f), based on the principle that an individual should be determined eligible based on his or her attestation during the period in which the Exchange is seeking additional information.

Next, in paragraph (d)(3)(iii)(D), we propose that the Exchange make reasonable

attempts to contact any employer identified on the application for the applicant and the members of his or her household, as defined in 26 CFR 1.36B-1(d) to verify whether the applicant is enrolled in an eligible employer-sponsored plan or is eligible for qualifying coverage in an eligible employer-sponsored plan for the benefit year for which coverage is requested. We expect that this will involve the Exchange using the employment information provided by an applicant and contacting employers via phone or mail.

One alternative we considered was to rely on consumers to obtain information from their employer or employers. We chose not to take this approach since the application will already solicit all necessary information from consumers, and so it is unclear what would be gained through a second information request to consumers. We seek comment on this alternative and others to implement this process while minimizing burden on consumers, employers, and Exchanges. We also seek comment on ways the Exchange can most efficiently interact with employers, including other entities that employers may rely upon to support this process, such as third-party administrators.

In paragraph (d)(3)(iii)(E), we propose that if the Exchange receives any information from an employer relevant to the applicant's enrollment in an eligible employer-sponsored plan or eligibility for qualifying coverage in an eligible employer-sponsored plan, the Exchange will determine the applicant's eligibility based on such information and in accordance with the effective dates specified in §155.330(f) of this subpart and if such information changes his or her eligibility determination, notify the applicant and his or her employer or employers of such determination in accordance with the notice requirements specified in 155.310(g) and (h) of this part. We propose to limit notifications to situations in which the information provided by an employer changes an applicant's eligibility determination, as notifying an applicant that his or her eligibility is unchanged requires additional effort and could be confusing. We anticipate that as an alternative, the initial notice that indicates that the Exchange will be requesting additional

information from an applicant's employer will state that the Exchange will notify him or her if anything changes based on additional information received by the Exchange. We solicit comments on this approach.

In paragraph (d)(3)(iii)(F), we propose that if, after a period of 90 days from the date on which the notice described in paragraph (d)(3)(iii)(A) of this section is sent to the applicant, the Exchange is unable to obtain the necessary information from an employer, the Exchange will determine the applicant's eligibility based on his or her attestation regarding that employer. If an individual has multiple employers, and not all employers provide information, the Exchange would determine eligibility based on the information provided by the employers that did respond, along with the information submitted by the applicant with respect to the employers that did not respond. We note that we do not propose that the Exchange provide an additional notice to the applicant and his or her employer based on the actions specified in paragraph (d)(3)(iii)(F), as using the applicant's attestation at the close of the 90-day period would by definition mean that his or her eligibility is unchanged. This is consistent with our approach in paragraph (d)(3)(iii)(E). As with that approach, we seek comment on this proposal and whether it is preferable to include an additional notice to the applicant and employer at the end of the 90-day period.

Finally, in paragraph (d)(3)(iii)(G), we propose that in order to carry out the process described in paragraph (d)(3)(iii) of this section, the Exchange must only disclose an individual's information to an employer to the extent necessary for the employer to identify the employee. This is the only disclosure that we believe is necessary to support this verification process. An employer will receive separate notice from the Exchange regarding an employee who is eligible for advance payments of the premium tax credit and cost-sharing reductions, as well as the employer's right to appeal.

We seek comments on this proposed approach and whether there are ways these

procedures can further minimize burden on the Exchange, employers, and consumers. We also note that consistent with proposed paragraph (d)(4), an Exchange can elect to have HHS conduct the entire verification process described under paragraph (d), including sampling and inconsistency resolution.

We note that other sections of the Exchange final rule and the proposed regulation ensure that eligibility determinations are being made based on the most accurate information available regarding enrollment in an eligible employer-sponsored plan and eligibility for qualifying coverage in an eligible employer-sponsored plan. Specifically, in §155.310(h), we specify standards for providing employers with a notice alerting them of their employee's eligibility for advance payments of the premium tax credit or cost-sharing reductions. Further, in §155.555, we propose a process through which employers can appeal the finding that an employee's coverage is unaffordable or does not meet minimum value. The verification procedures presented in this section along with these notice and appeals provisions will ensure that that employers can challenge eligibility determinations for advance payments of the premium tax credit that are made based on the Exchange's findings about the coverage they offer to their employees. This entire system, taken together, ensures that consumers and employers are protected from adverse consequences of inaccurate determinations.

In addition to the verification procedures proposed this section, we are taking steps to help consumers with providing information related to access to employer-sponsored coverage on the application. We suggest the use of a voluntary pre-enrollment template to assist applicants in gathering the information about access to coverage through an eligible employer-sponsored plan as required by the Exchange to determine eligibility for advance payments of the premium tax credit and cost-sharing reductions. We envision that an applicant would download a one-page template from the Exchange web site and present the document to his or her employer (or the employer of his or her spouse or parent). This template would enable the applicant to gather the

information necessary from the relevant employer regarding the employer's coverage offerings.

Alternatively, an employer could voluntarily download and populate the template with information regarding its coverage offerings and distribute to employees at hiring, upon request, on the employer intranet or benefit site, or in conjunction with other information about employer-sponsored coverage provided by the employer to employees. When an individual completes his or her Exchange application, he or she would provide the information from the completed template in response to relevant questions on the single, streamlined application. We seek comments on the use of this pre-enrollment template and ways it can be used to assist consumers with providing the necessary information to complete the verification described in this paragraph while minimizing burden on employers. Elements of this tool can be commented upon as part of the information collection request related to the Supporting Statement for Data Collection to Support Eligibility Determinations for Insurance Affordability Programs and Enrollment through Health Benefits Exchanges, Medicaid, and Children's Health Insurance Program Agencies (CMS-10440). We intend to release the template for comment in the near future.

We also propose, pursuant to authority under section 1411(d) of the Affordable Care Act, that an Exchange may rely on HHS to complete this verification. We first indicated that we were exploring this in a set of questions and answers released on November 29, 2011[2], and we received a significant amount of feedback from states indicating that this would be useful. As outlined in paragraph (d)(4), we propose that the Exchange may satisfy the provisions of this paragraph by implementing a verification process performed by HHS, provided that the Exchange sends the notices described in 45 CFR 155.310(g) and (h) of this part; other activities required in connection with the verifications described are performed by the Exchange in accordance with the standards identified in this subpart or by HHS in accordance with the

agreement described in paragraph (d)(4)(iv) or this section; the Exchange provides all relevant application information to HHS through a secure, electronic interface, promptly and without undue delay; and the Exchange and HHS enter into an agreement specifying their respective responsibilities in connection with the verifications described in this paragraph. We anticipate that under this option, the Exchange would collect an individual's attestations regarding eligibility for qualifying coverage in an eligible employer-sponsored plan and integrate the verification outcome in to the eligibility determination for advance payments of the premium tax credit and cost-sharing reductions, and HHS would provide the other components of the process. We welcome comments on this proposed option.

We propose to remove paragraph (e) as it has been incorporated into §155.320(d). Due to removing this paragraph, we propose to redesignate paragraph (f) as paragraph (e).

14. Eligibility redetermination during a benefit year (§155.330)

We propose to amend paragraph (d)(1)(ii) to clarify that the Exchange will conduct periodic examination of data sources to identify eligibility determinations for Medicare, Medicaid, CHIP, or the BHP, if a BHP is operating in the service area of the Exchange, only for enrollees on whose behalf advance payments of the premium tax credit or cost-sharing reductions are being provided, as opposed to all QHP enrollees, since this information is not relevant to eligibility for enrollment in a QHP without advance payments and cost-sharing reductions.

In 45 CFR 155.330(e)(1)(ii) and 155.335(c) of the Exchange final rule, we describe how the Exchange must notify an enrollee of his or her redetermination as the result of situations in which an enrollee reports a change in circumstance, or the Exchange conducts limited periodic data matching or an annual redetermination. We seek comment on adding a provision such that if an enrollee experiences a change in his or her level of cost-sharing reductions as a result of a

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[2] http://cciio.cms.gov/resources/files/Files2/11282011/exchange_q_and_a.pdf.pdf

redetermination occurring under 45 CFR 155.330(e)(1) or 155.335(c), the notice issued by the Exchange will describe how the enrollee's amount of deductibles, co-pays, coinsurance, and other forms of cost sharing would change as a result of the change in level of cost-sharing reductions if the enrollee stays in the same QHP (and only changes plan variations). We note that an enrollee who experiences a change in the level of cost-sharing reductions as a result of a redetermination will qualify for a special enrollment period to change QHP's, in accordance with §155.420(d)(6). We believe that including this information in the notice describing how the enrollee's amount of deductibles, co-pays, coinsurance, and other forms of cost sharing would change as a result of the change in level of cost-sharing reductions if the enrollee stays in the same QHP (and only changes plan variations) will be particularly important in the event an individual does not decide to change QHPs during the special enrollment period. We solicit comment on whether HHS should adopt this approach.

We propose to consolidate and revise existing paragraphs (e)(2) and (e)(3) into new paragraph (e)(2) to clarify how the Exchange should proceed when data matching indicates that an individual is deceased. In paragraph (e)(2)(i), we clarify the procedures that the Exchange will follow for data matches that indicate that an individual is deceased. Clarifying the application of these procedures permits the Exchange to properly effectuate an eligibility redetermination based on death without a response from the individual who data indicates is deceased, as the deceased enrollee will not be able to respond and confirm the updated information. We also note that the procedures in paragraph (e)(2)(i) provide an opportunity for an individual to address incorrect data matches in the extremely limited situations in which they may occur.

In revised paragraph (e)(2)(ii), we propose the process the Exchange follows after identifying updated information regarding income, family size, or family composition through data matching; we reiterate that information regarding death does not require the Exchange to

follow these procedures. The only difference between this proposal for paragraph (e)(2)(ii)(B) and new paragraph (e)(2)(ii)(D) and the regulation text in its current form is to clarify that if an enrollee provides more up-to-date information in response to the notice regarding the information identified through periodic data matching, the Exchange will proceed in accordance with paragraph (c)(1), which provides procedures for verification of enrollee-reported changes. The prior language did not specify that enrollee-reported information would be subject to verification, which was an oversight we propose to rectify here.

We propose to amend paragraph (f) to incorporate changes as a result of eligibility appeals decisions, as well as changes that affect only enrollment or premiums, but do not affect eligibility. Changes affecting only enrollment or premiums include those changes that must be submitted to health insurance issuers as part of an enrollment transaction, but do not require an eligibility redetermination. Examples include name changes, phone number changes, or changes to the amount of tax credit a household elects to apply to its premium. Incorporating concerns from states, the proposed changes to paragraph (f) are designed to bring the effective dates under this section in line with the effective dates for enrollment, as specified in subpart E, which are aligned with the typical QHP billing cycle. In particular, we note that the process used to provide initial enrollment information to QHP issuers will be the same as the process used to provide updates, and so the ability to create parallel timing should support efficient operations. The modified effective dates are also designed to accommodate the limited situations in which retroactive eligibility may be necessary. We note that advance payments of the premium tax credit and cost-sharing reductions may only be provided for a "coverage month" as defined in 26 CFR 1.36B-3(c).

First, in paragraph (f)(1), we propose that, except as specified in paragraphs (f)(2) through (f)(7), the Exchange must implement the changes as described in paragraph (f)(1). As proposed here, paragraph (f)(1)(i) provides that changes resulting from a redetermination under

this section must be implemented on the first day of the month following the date of the notice described in paragraph (e)(1)(ii) of this section. We propose in paragraph (f)(1)(ii) that changes resulting from an appeal decision under subpart F must be implemented on the first day of the month following the date of the notices described in §§155.545(b) and 155.555(k), or on the date specified in the appeal decision pursuant to §155.545(c)(1). As the Exchange will not be required to provide a notice for changes affecting only enrollment through the Exchange or premiums, the Exchange must implement the changes as described in paragraph (f)(1)(iii) based instead on when the Exchange is notified of the change. We anticipate that this notice may come from the enrollee or the QHP issuer, depending on the nature of the change. We propose to amend paragraph (f)(2) to clarify that except as specified in paragraphs (f)(3) through (f)(7) of this section, the Exchange may determine a reasonable point in a month, no earlier than the 15th of the month, after which a change as described in paragraph (f)(1) of this section will not be effective until the first day of the month after the month specified in paragraph (f)(1) of this section. This proposal is designed to align the effective dates for redeterminations to align with the effective dates for enrollment, as specified in subpart E of this part, which provide that in general, a QHP selection will be effective on the first of the month following the selection only if the selection is made by the 15th of the month.

We propose to redesignate current paragraph (f)(3) as paragraph (f)(7), and propose a new paragraph (f)(3) to provide that except as specified in paragraph (f)(7) of this section, the Exchange must implement a change described in paragraph (f)(1) of this section resulting in a decreased amount of advance payments of the premium tax credit or cost-sharing reductions, including when an individual becomes newly ineligible for advance payments of the premium tax credit or cost-sharing reductions, and for which the date of the notices described in paragraphs (f)(1)(i) and (ii) of this section, or the date on which the Exchange is notified in accordance with paragraph (f)(1)(iii) of this section is after the 15th of the month, on the first day

of the month after the month specified in paragraph (f)(1) of this section. We provide this exception to paragraph (f)(1) because a decrease in the amount of cost-sharing reductions effectuated after the 15th of the month results in operational challenges for issuers due to the nature of QHP billing cycles. We understand that cost-sharing reductions will be applied at the point-in-time in which an enrollee pays for their services, and thus the potential for a retroactive decrease in cost-sharing reductions will pose complications regarding services for which the enrollee has already paid. Similarly a retroactive decrease in advance payments of the premium tax credit will also create problems for issuers regarding the billing of previous premiums. Thus, we propose that they also be effectuated on the first day of the month after the month specified in paragraph (f)(1) of this section.

We propose to add paragraph (f)(4) to provide that except as specified in paragraph (f)(7) of this section, the Exchange must implement changes that result in an increased level of cost-sharing reductions and for which the date of the notices described in paragraphs (f)(1)(i) and (ii) of this section, or the date on which the Exchange is notified in accordance with paragraph (f)(1)(iii) of this section is after the 15th of the month, on the first day of the month after the month specified in paragraph (f)(1) of this section. As discussed above concerning paragraph (f)(3) of this section, a retroactive increase in the level of cost-sharing reductions will pose complications for issuers regarding those services that the enrollee has already paid for. As such, we also propose that the changes in paragraph (f)(4) be implemented effective the first day of the month after the month specified in paragraph (f)(1) of this section.

We propose to add paragraph (f)(5) to provide that the Exchange may implement a change associated with the events specified in §155.420(b)(2)(i) and (ii) (birth, adoption, placement for adoption, marriage, and loss of minimum essential coverage) on the coverage effective dates described in §155.420(b)(2)(i) and (ii) respectively, and will ensure that advance payments of the premium tax credit and cost-sharing reductions are effective on the first day of

the month following such events, unless the event occurs on the first day of the month. These changes are to align the effective dates for eligibility with those specified in §155.420. We also considered whether to adjust eligibility effective dates for the purposes of advance payments of the premium tax credit and cost-sharing reductions in cases of birth, adoption, or placement for adoption such that eligibility for APTC and CSR would be effective on the date of birth, adoption, or placement for adoption. However, we do not believe that current regulations under section 36B of the Code address this situation. We expect that the Secretary of the Treasury will provide through subsequent guidance that a child may be eligible for the premium tax credit for the month the child is born or is adopted, placed for adoption, or placed in foster care. We expect to amend our regulations as necessary in final rulemaking to match the guidance from the Secretary of the Treasury. We note that the special enrollment period described in §155.420(b)(2)(i) does not currently address children placed in foster care, and we solicit comments regarding whether we should expand it to cover children placed in foster care, and then make a corresponding change to eligibility effective dates in this paragraph.

We propose to add paragraph (f)(6) specifying that notwithstanding paragraphs (f)(1) through (f)(5) of this section, the Exchange may implement a change associated with the events described in §155.420(d)(4), (5), and (9) based on the specific circumstances of each situation. We seek to provide flexibility for the Exchange to respond to these potential errors, violations, or exceptional circumstances as needed to effectuate the appropriate eligibility date for enrollees, including those situations that impact the amount of advance payments of the premium tax credit and cost-sharing reductions, while also minimizing operational complications for issuers associated with the QHP billing cycle. We reiterate here that advance payments of the premium tax credit and cost-sharing reductions may only be provided for a "coverage month" as defined in 26 CFR § 1.36B-3(c), which requires coverage to be in place on the first of the month; we note that the Exchange may not authorize these benefits for periods other than when an

individual is in a coverage month. In redesignated paragraph (f)(7), we propose to maintain the existing language of paragraph (f)(3) in accordance with the proposed changes throughout paragraph (f).

We welcome comments on these changes.

15. Annual eligibility redetermination (§155.335)

We propose to amend paragraphs (a), (b), (c), (e), (f), (g), (h), (k), and (l) of this section to specify that subject to the limitations specified in paragraph (l) and new paragraph (m), the Exchange will conduct an annual eligibility redetermination for all qualified individuals, not only those who are enrolled in a QHP. Our proposal thus replaces the word "enrollee" with the term "qualified individual" in these paragraphs. This change accommodates situations in which an individual submitted an application prior to the annual open enrollment period, was determined eligible for enrollment in a QHP with or without advance payments of the premium tax credit and cost-sharing reductions, and did not meet the criteria for a special enrollment period. In such situations, this change will mean that the Exchange will provide such an individual with an annual eligibility redetermination notice, which means that he or she will not have to submit a new application to obtain coverage for the following benefit year. The annual eligibility determination notice projects eligibility for the upcoming benefit year, and provides a streamlined process for individuals to select a QHP for the upcoming year during the annual open enrollment period.

We propose to amend paragraph (b) to include data regarding Social Security benefits as defined under 26 CFR 1.36B-1(e)(2)(ii). This reflects the revision we propose to make in §155.320(c)(1)(i)(A).

We also propose to make technical corrections to paragraph (l) to specify that if the Exchange does not have authorization to use such qualified individual's tax information, the Exchange will redetermine the qualified individual's eligibility only for enrollment in a QHP,

and will notify the enrollee in accordance with the timing described in paragraph (d) of this section. This proposed correction aligns with the preamble from the Exchange final rule at 77 FR 18376.

Lastly, we propose to add new paragraph (m), which provides that if a qualified individual does not select a QHP before the redetermination described in this section, and is not enrolled in a QHP through the Exchange at any time during the benefit year for which such redetermination is made, the Exchange must not conduct a subsequent redetermination of his or her eligibility for a future benefit year. This proposal is designed to ensure that a qualified individual who never selects a QHP is not redetermined every year, which minimizes burden on the Exchange. For example, if a qualified individual seeks to enroll in a QHP in July, 2014, is determined eligible for a QHP but not a special enrollment period, and then following an annual redetermination in late 2014 for the 2015 benefit year is again determined eligible in a QHP but decides not to enroll at any time up to the point at which the Exchange would conduct his or her next annual redetermination (late 2015), the Exchange will not conduct another annual redetermination in late 2015.

16. Administration of advance payments of the premium tax credit and cost-sharing reductions (§155.340)

We propose to make technical corrections in paragraphs (b) and (c) to cite to the applicable Treasury regulation instead of Section 36B of the Code.

17. Coordination with Medicaid, CHIP, the Basic Health Program, and the Pre-existing Condition Insurance Plan (§155.345)

We propose to make a technical correction to paragraph (a) to clarify that the agreements that the Exchange enters into with the agencies administering Medicaid, CHIP, and the BHP, if the BHP is operating in the service area of the Exchange, must include a clear delineation of the responsibilities of each "agency" as opposed to each "program." We propose to amend

paragraph (a)(2) to specify that the agreement the Exchange enters into with other agencies administering insurance affordability programs addresses the responsibilities of each agency to ensure prompt determinations of eligibility and enrollment in the appropriate program without undue delay, based on the date the application is submitted to, or redetermination is initiated by, the Exchange or another agency administering an insurance affordability program. We propose to change the ordering of agencies listed for purposes of clarity. We also propose to redesignate paragraph (a)(3) as paragraph (a)(4), and add a new paragraph (a)(3) to ensure that, as of January 1, 2015, the agreement provides for a combined eligibility notice, as defined in §435.4, to individuals and members of the same household, to the extent feasible, for enrollment in a QHP through the Exchange and for all insurance affordability programs. Section 155.345(a)(3)(i) includes that prior to January 1, 2015, the notice include coordinated content, as defined in 42 CFR 435.4, while §155.345(a)(3)(ii) addresses the combined eligibility notice requirement as of January 1, 2015. As defined in §435.4, a combined eligibility notice is an eligibility notice that informs an individual, or household when appropriate, of his or her eligibility for eligibility for enrollment in a QHP and each of the insurance affordability programs. We are proposing that in most cases the combined notice is issued by the last agency to determine the individual's eligibility, not taking into account eligibility determinations for Medicaid on a non-MAGI basis, and regardless of which agency initially received the application. Providing a combined eligibility notice for eligibility determinations for enrollment in a QHP and for insurance affordability programs, with the exception of eligibility determinations for Medicaid on a non-MAGI basis, would reduce the occurrence of an individual receiving multiple eligibility notices from agencies administering insurance affordability programs based on a single application. To the extent that the eligibility determinations reflected in a combined notice are not made by the agency issuing the notice, the notice should identify the agency that made each eligibility determination that is reflected in the combined notice.

We acknowledge that there are situations in which the provision of a combined eligibility notice may not be appropriate, and expect that agencies administering insurance affordability programs will limit the use of combined eligibility notices to only those situations in which it is beneficial to the applicant. The preamble associated with §435.1200 describes situations in which the combined eligibility notice may not be appropriate. We request comments on situations in which the combined eligibility notice may or may not be particularly appropriate.

We understand that it may not be operationally feasible for the Exchange and state agencies administering Medicaid, CHIP, and the BHP, if the BHP is operating in the service area of the Exchange, to deliver combined eligibility notices by October, 1, 2013, particularly in cases where the Exchange is performing assessments of eligibility for Medicaid and CHIP based on MAGI in accordance with §155.302(b). Accordingly, we are proposing a phased-in approach for the provision of a combined eligibility notice in cases where the Exchange is performing assessments of eligibility for Medicaid and CHIP based on MAGI. We propose that the agreements between the Exchange and other agencies administering insurance affordability programs provide for provision of combined eligibility notices by January 1, 2015.

For the period prior to January 1, 2015, when an individual submits an application to the state Medicaid agency, is denied eligibility for Medicaid, found not potentially eligible for CHIP, and is transferred to the Exchange, the state Medicaid agency would send a first notice to an individual, explaining that the individual is denied eligibility for Medicaid, and that the individual's information is being transferred to the Exchange for a determination of eligibility for enrollment in a QHP and for advance payments of the premium tax credit and cost-sharing reductions. The Exchange would then send a second notice explaining the individual's eligibility for enrollment in a QHP and for advance payments of the premium tax credit and cost-sharing reductions. However, after January 1, 2015 and to the extent feasible -- when sending a combined notice is part of the agreement among the relevant agencies -- in the same scenario, the

Exchange would provide a combined eligibility notice that includes information about the individual's denial of eligibility for Medicaid and eligibility for enrollment in a QHP and for advance payments of the premium tax credit and cost-sharing reductions because the Exchange is the last agency to make an eligibility determination. The provision of a combined eligibility notice would also mean that if the Exchange is transferring an individual's information to the state Medicaid or CHIP agency and the individual is Medicaid or CHIP eligible, the Medicaid or CHIP agency would issue the combined eligibility notice that reflects both the findings of the Exchange (not eligible for enrollment in a QHP or advance payments of the premium tax credit or cost-sharing reductions) and of the Medicaid and CHIP agencies (eligible for Medicaid or CHIP).

Under §155.345(a)(3) and (g)(7) of this proposal, we propose that the Exchange implement the use of a combined eligibility notice as of January 1, 2015, to the extent feasible, and in the interim, provide for the use of coordinated content in the eligibility notice. The Exchange will work with agencies administering other insurance affordability programs to ensure the inclusion of coordinated content, including coordinated language, in eligibility determination notices. An example of coordinated content would include information about the Exchange and about insurance affordability programs, including specific program names and customer service information for each program, as applicable. Based on the operational readiness of the Exchange and other agencies administering insurance affordability programs, combined eligibility notices may be implemented earlier. However, we note that in states where the FFE is conducting assessments rather than final determinations of eligibility, the FFE will only be able to provide an eligibility notice prior to January 1, 2015 for eligibility determinations made by the FFE.

We request comments on the phased-in approach and the standards proposed related to the provision of a combined eligibility notice and the use of coordinated content for eligibility

notices by the Exchange and agencies administering insurance affordability programs, which would include information about the Exchange and about insurance affordability programs, including specific program names and customer service information for each program, as applicable. We have been working in consultation with relevant stakeholders on model notices, and intend to release model notices in early 2013 for use by states that want to rely on HHS' templates for notices instead of developing their own. We also request comments regarding how to assess when provision of a combined eligibility notice is feasible.

We propose to make a technical correction in paragraph (f) to cite to the applicable Treasury regulation instead of Section 36B of the Code.

We propose to make a technical correction to paragraph (g) to change "or" to "and" and add "agency or."

We propose to add new language at paragraph (g)(2) to specify that the Exchange will notify the transmitting agency of the receipt of an electronic account when another agency is transmitting the account to the Exchange in the situation in which an application is submitted directly to the transmitting agency, and a determination of eligibility is needed for enrollment in a QHP, advance payments of the premium tax credit, and cost-sharing reductions. Additionally, we propose in (g)(2) that the Exchange notify the transmitting agency of an individual's eligibility determination for enrollment in a QHP, advance payments of the premium tax credit, and cost-sharing reductions. This aims to ensure that the Exchange can provide effective customer service, while also aligning with proposed §435.1200(d)(5).

As such, we propose to make technical corrections to redesignate the paragraphs following paragraph (g)(2). We redesignate paragraph (g)(2) to (g)(3), (g)(3) to (g)(4), (g)(4) to (g)(5), and (g)(5) to (g)(6).

We propose to make a technical correction in paragraph (g)(3) to change "program" to "agency."

We propose to make technical corrections to paragraph (g)(4) to change "of" to "or," and to clarify that the rule is referring to an agency administering an insurance affordability program.

We propose to make a technical correction to remove "and" at the end of paragraph (g)(5) and add it at the end of paragraph (g)(6) to provide for the appropriate transition to paragraph (g)(7).

We propose to add paragraph (g)(7) to direct that the Exchange provide the combined eligibility notice, as defined in §435.4, for eligibility determinations for enrollment in a QHP and for insurance affordability programs, effective on January 1, 2015.

We propose to add paragraph (g)(8) to direct that prior to January 1, 2015, the Exchange include coordinated content, as defined in 42 CFR 435.4, into the notice of eligibility determination provided to the individual when another agency administering an insurance affordability program transfers an individual's account to the Exchange, or that the Exchange issue a combined eligibility notice when the Exchange is the last agency to make an eligibility determination, except for an eligibility determination for Medicaid on a non-MAGI basis. The intent of this provision is to allow the Exchange flexibility to provide coordinated content or a combined eligibility notice, in the event an Exchange is able to provide a combined eligibility notice, prior to January 1, 2015. As noted previously, we understand that the Exchange may not be operationally ready to issue a combined eligibility notice prior to 2015, and so have designed this proposal to allow an appropriate phase-in period.

18. Special eligibility standards and process for Indians (§155.350)

We propose to make a technical correction in paragraph (a)(1)(ii) to cite to the applicable Treasury regulation instead of section 36B of the Code.

19. Enrollment of qualified individuals into QHP's (§155.400)

We propose to add paragraph (b)(3) to clarify the earlier requirement in 45 CFR 155.400(b)(1) that the Exchange send eligibility and enrollment information to QHP issuers and

HHS promptly and without undue delay. In this section, we propose that the Exchange send HHS updated eligibility and enrollment information. We interpret the requirement concerning "updated eligibility and enrollment information" to mean all enrollment-related transactions, including, but not limited to, enrollments sent to issuers for which the qualified individual has not yet remitted premiums, enrollments for which payment has been made on any applicable enrollee premium, cancellations of enrollment prior to coverage becoming effective, terminations of enrollment, and enrollment changes (to include terminations and cancellations initiated by issuers).

20. Special enrollment periods (§155.420)

Section 1311(c)(6)(C) of the Affordable Care Act specifies that the Secretary shall require Exchanges to provide for special enrollment periods, which allow a qualified individual to enroll in a QHP, add or drop dependents enrolled with the qualified individual, or change from one QHP to another outside of the annual open enrollment period. We implemented this provision in section 155.420 of the Exchange final rule published March 27, 2012 (77 FR 18310). The statute further specifies that such periods should be those specified in section 9801 of the Code, as well as other special enrollment periods under circumstances similar to such periods under part D of title XVIII of the Act. Section 155.420 is structured such that the special enrollment periods are listed in paragraph (d), while the effective dates for these special enrollment periods are described in paragraph (b).

In order to clarify the scope of the special enrollment periods described in paragraph (d), we propose to redesignate existing paragraph (a) as paragraph (a)(1) and to add paragraph (a)(2) to define "dependent" such that it aligns with the meaning provided in 26 CFR § 54.9801-2, a regulation implementing section 9801(f) of the Code.[3] Under this proposal, a dependent would

[3] Note that the special enrollment periods specified in section 9801(f) of the Code are also required in section 701 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 2704 of the PHS Act. (Before the

include any individual who is or who may become eligible for coverage under the terms of a QHP because of a relationship to a qualified individual or enrollee. This proposal does not broaden our existing use of dependent throughout this section; rather, it clarifies our existing interpretation such that the availability of special enrollment periods to dependents is limited to those dependents for whom the selected QHP would provide coverage. We propose to apply this definition throughout this section, including for the special enrollment periods not specified in section 9801(f) of the Code, in order to promote efficient operations and uniform standards to guide QHP issuers and Exchanges. We note that this proposal means that those special enrollment periods that specifically mention dependents will be evaluated on a plan-by-plan basis for a given set of individuals, and that a special enrollment period may be available for an individual in some plans but not in other plans.

We also propose to amend paragraph (b)(2)(i), which addresses birth, adoption, or placement for adoption, to clarify that this special enrollment period is applicable for either "a qualified individual or an enrollee." This revision clarifies the existing language in the Exchange final rule, which could have been misinterpreted. We also propose to remove language from paragraph (b)(2)(i) concerning the effective dates for advance payments of the premium tax credit and cost-sharing reductions, which we propose to move to §155.330(f). We solicit comments regarding whether we should also expand this special enrollment period to cover children placed in foster care. Similarly, we propose to amend paragraph (b)(2)(ii) to clarify that the special enrollment period for marriage and loss of minimum essential coverage is applicable for either a qualified individual or an enrollee.

We propose to add new paragraph (b)(2)(iii) regarding effective dates for qualified

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amendments made by the Affordable Care Act, the special enrollment provisions were located in section 2701(f) of the PHS Act; after the amendments made by the Affordable Care Act, these requirements are found in PHS Act section 2704(f).) Similarly, the special enrollment periods specified 26 CFR. § 54.9801-2 are also found in 29 CFR 2590.701-6 and 45 CFR 146.117.

individuals or enrollees eligible for a special enrollment period under paragraphs (d)(4), (d)(5) or (d)(9) (respectively the special enrollment period for "error, misrepresentation, or inaction of an officer, employee, or agent of the Exchange, HHS, or its instrumentalities"; the special enrollment period for when "the QHP … substantially violated a material provision of its contract in relation to the enrollee"; and the special enrollment period for "exceptional circumstances"). Under this proposal, the Exchange will ensure an effective date that is tailored based on the circumstances around the specific events. This will include, in accordance with any guidelines issued by HHS, providing, when applicable and on a case-by-case basis, that coverage will be effective in accordance with the regular effective dates specified in paragraph (b)(1) or on the date of the event that triggered the special enrollment period under paragraphs (d)(4), (d)(5), or (d)(9) of this section. We believe the nature of the circumstances that will trigger these special enrollment periods make it necessary to provide the Exchange with appropriate flexibility regarding coverage effective dates. We have proposed a similar provision in §155.330(f), and welcome comments on standards for effective dates in such situations.

We propose to add paragraph (b)(4) to specify that notwithstanding the standards otherwise provided in this section, the Exchange must ensure that the effective dates concerning advance payments of the premium tax credit and cost-sharing reductions adhere to the modified effective dates we have proposed in §155.330(f). This is designed to bring the effective dates under this section, which are aligned with the typical QHP billing cycle, in line with the effective dates for eligibility, as specified in subpart D. While §155.330(f) concerns redeterminations and other changes during the benefit year, we clarify that the effective enrollment dates concerning §155.420(b) apply to both qualified individuals first enrolling in a QHP through the Exchange via a special enrollment period, as well as to current enrollees. We also note that as in existing regulations, there are situations in which eligibility and enrollment effective dates will not perfectly align, such that an enrollment effective date might be immediate, but advance payments

of the premium tax credit and cost-sharing reductions might not be effective until the first of a future month.

Accordingly, as noted above, we propose to make a technical correction to remove part of paragraph (b)(2)(i), as well as paragraphs (b)(3)(i)(A) and (B) to remove language concerning advance payments of the premium tax credit and cost-sharing reductions and propose to make a technical correction in paragraph (b)(3)(i) to remove the words "provided that either" at the end of the paragraph to reflect this change.

We next propose to amend paragraph (d) to specify that the Exchange must allow, when specified in the paragraphs therein, for a dependent of a qualified individual or enrollee to qualify for a special enrollment period. The previous language allowed a qualified individual or enrollee to qualify for the listed special enrollment periods. The proposed language allows that for certain triggering events specified in paragraph (d), the Exchange will determine a qualified individual or enrollee, as well as his or her dependents, eligible for a special enrollment period, subject to whether the QHP that such individuals wish to select covers the dependents. Therefore, for specified special enrollment periods, a qualified individual or enrollee who experiences the triggering event will be eligible for the special enrollment period, along with any dependents able to enroll in the plan selected for the qualified individual or enrollee. For example, if a 25 year old loses access to minimum essential coverage, he will qualify for a special enrollment period, along with his parents and any other dependents who may enroll in the plan selected.

We propose amending this language in order to accommodate situations in which all members of a household would likely need to enroll in or change QHPs in response to an event experienced by one member of the household. We also propose to make technical corrections to each paragraph within paragraph (d) to replace the introductory word "A" with "The" in order to reflect that in response to each triggering event, the Exchange will allow a qualified individual or

enrollee, and when specified, his or her dependent to qualify for a special enrollment period, subject to whether the QHP covers the dependent.

We also propose to make a technical change to paragraph (d)(1) to add the words "his or her" after "The qualified individual or". We also propose to clarify the triggering events associated with a qualified individual or his or her dependent losing minimum essential coverage. We propose to add paragraph (d)(1)(i) to specify that the triggering event in the case of a QHP decertification is the date of the notice of decertification as described in §155.1080(e)(2). We also propose to add paragraph (d)(1)(ii) to specify that the triggering event in all other cases is the date the individual or dependent loses eligibility for minimum essential coverage. This proposal adds specificity regarding these triggering events in order to minimize gaps in coverage for a qualified individual or his or her dependent.

We propose to amend paragraphs (d)(3) through (d)(7), as well as (d)(9), to clarify the specific individuals that are affected by the eligibility of a qualified individual for each special enrollment period. In paragraph (d)(3), we make a technical correction to add the word, "qualified", before "individual", to specify that only a qualified individual may be eligible for the special enrollment period for an individual who was not previously a citizen, national, or lawfully present gaining such status. In paragraphs (d)(4), (d)(5), (d)(7), and (d)(9) (concerning errors in enrollment, contract violations, permanent relocations, and exceptional circumstances), we specify that these special enrollment periods apply to a qualified individual or enrollee, as well as to his or her dependent. This is because errors in enrollment, contract violations, permanent relocations, and exceptional circumstances that affect only one individual, to the extent that this occurs, will likely result in him or her needing to change QHPs for his or her entire family. We considered similar amendments for other special enrollment periods, but decided not to revise them, as we do not believe that the circumstances of other special enrollment periods warrant movement of related individuals. However, we solicit comment

regarding whether we should permit such movement of related individuals for other special enrollment periods.

We further propose to amend paragraph (d)(6) to specify that the Exchange will provide a special enrollment period for (i) an enrollee in a QHP who is determined newly eligible or newly ineligible for advance payments of the premium tax credit or experiences a change in eligibility for cost-sharing reductions, (ii) his or her dependent who is an enrollee in the same QHP and who is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost sharing reductions, or (iii) a qualified individual or his or her dependent enrolled in qualifying coverage in an eligible employer-sponsored plan who are determined newly eligible for advance payments of the premium tax credit based in part on a finding that such individual will cease to be eligible for qualifying coverage in an eligible-employer sponsored plan in the next 60 days, and is allowed to terminate existing coverage. Proposed paragraph (d)(6)(iii) differs from paragraphs (d)(6)(i) and (ii) in that it allows the qualified individual or his or her dependent to be determined eligible for this special enrollment period and the opportunity to enroll in a new QHP prior to the end of his or her employer-sponsored coverage. However, he or she is not eligible to receive advance payments of the premium tax credit until the end of his or her coverage through such eligible employer-sponsored plan. The existing language provided this special enrollment period regardless of an individual's current coverage status, which could have resulted in any individual who did not apply during the initial annual open enrollment period being able to receive a special enrollment period. This could have been disruptive to the market, because the potential for an individual to be eligible for this special enrollment period regardless of his or her coverage status could heighten adverse selection by dissuading more healthy individuals from enrolling in a QHP during the initial annual open enrollment period. We provide this special enrollment period for the dependent of an enrollee determined newly eligible or newly ineligible for

advance payments of the premium tax credit or an enrollee experiencing a change in eligibility for cost-sharing reductions to account for situations where members of different tax households are enrolled together in the same plan and otherwise would be prevented from enrolling together in a new plan during the special enrollment period.

We also specify in paragraph (d)(6) that the Exchange must permit a qualified individual, or his or her dependent, enrolled in qualifying coverage in an eligible employer-sponsored plan who are eligible for this special enrollment period due to their plan no longer being affordable or providing minimum value within the next 60 days prior to the end of his or her coverage, to access this special enrollment period prior to the end of his or her coverage through such an eligible employer-sponsored plan if he or she is allowed to terminate existing coverage. This protects those qualified individuals from potential gaps in coverage, while also outlining a reasonable period of time in which they are eligible for this special enrollment period such that it does not pose significant operational complications for the Exchange.

We propose to make a technical correction to paragraph (d)(8) such that the beginning of the paragraph now reads, ”The qualified individual who is an Indian”. The previous language did not specify that this special enrollment period was limited to a qualified individual.

Finally, we propose to add a new paragraph (d)(10) to provide a special enrollment period for a qualified individual or his or her dependent, who is enrolled in an eligible employer-sponsored plan that does not provide qualifying coverage, as the term is defined in §155.300 of this part, and is allowed to terminate his or her existing coverage. Under this proposal, the Exchange would permit such an individual to access this special enrollment period 60 days prior to the end of his or her coverage in an eligible employer-sponsored plan. This protects those qualified individuals from potential gaps in coverage and ensures that a qualified individual and his or her dependent would not be prevented from enrolling together in a QHP during the special enrollment period; we note that an individual’s eligibility for advance payments of the premium

tax credit and cost-sharing reductions will still be subject to termination of existing enrollment in an eligible employer-sponsored plan.

21. Termination of coverage (§155.430)

We propose to amend paragraph (b)(1) to clarify that it specifically refers to enrollee-initiated terminations. We further propose to divide paragraph (b)(1) into two paragraphs. We propose to add paragraph (b)(1)(i) to account for circumstances in which, through periodic data matching, an Exchange finds an enrollee eligible for other minimum essential coverage, thus resulting in the enrollee's ineligibility for advance payments of the premium tax credit. The Exchange final rule currently provides that enrollees must actively terminate their enrollment in a QHP after losing eligibility for advance payments of the premium tax credit and cost-sharing reductions, or otherwise the enrollee will remain enrolled in multiple plans, since gaining other minimum essential coverage does not affect eligibility for enrollment in a QHP. Under the existing rule, enrollees who did not initiate a termination upon gaining other minimum essential coverage would maintain coverage in a QHP without advance payments of the premium tax credit. HHS believes that the majority of individuals who gain other minimum essential coverage will not want to maintain coverage in a QHP without advance payments of the premium tax credit and cost-sharing reductions. To accommodate this anticipated preference, and allow individuals to maintain enrollment in a QHP in the limited number of situations in which they want to do so, we propose in paragraph (b)(1)(ii) that at the time of plan selection, the Exchange will provide a qualified individual with the opportunity to choose to remain enrolled in a QHP if the Exchange identifies that they have become eligible for other minimum essential coverage through data matching and the enrollee does not request a termination in accordance with paragraph (b)(1)(i). We solicit comment on this proposal.

We propose to amend paragraph (d)(1) to specify that changes in advance payments of the premium tax credit and cost-sharing reductions, including terminations, adhere to the

effective dates specified in §155.330(f), which ensures alignment of processes.

22. Subpart F--Appeals of Eligibility Determinations for Exchange Participation and Insurance Affordability Programs

This subpart is proposed to provide standards for eligibility appeals, including appeals of individual eligibility determinations and employer determinations as required by section 1411(f) of the Affordable Care Act, which makes clear that the Secretary will provide for an appeals process. We propose to provide Exchanges with options for coordinated appeals to align with the options for eligibility determinations. In addition, the following sections propose standards for appeal requests, eligibility pending appeal, dismissals, informal resolution and hearing requirements, expedited appeals, appeal decisions, the appeal record, and corresponding provisions for employer appeals.

23. Definitions (§155.500)

In this section, we propose definitions for this subpart, in addition to incorporating the definitions previously established in §155.20 and §155.300.

We propose the term "appeal record" to mean the appeal decision, all papers and requests filed in the proceeding, and, if a hearing was held, the transcript or recording of hearing testimony or an official report containing the substance of what happened at the hearing, and any exhibits introduced at hearing.

We propose the term "appeal request" to mean a clear expression, made either orally or in writing, by an applicant, enrollee, employer, or small business employer or employee to have any eligibility determination or redetermination contained in a notice issued in accordance with §§155.310(g), 155.330(e)(1)(ii), 155.335(h)(1)(ii), 155.715(e) or (f), or pursuant to future guidance on section 1311(d)(4)(H) of the Affordable Care Act adjudicated by an appeals entity.

We propose the term "appeals entity" to mean a body designated to hear appeals of eligibility determinations or redeterminations contained in notices issued in accordance with

§§155.310(g), 155.330(e)(1)(ii), 155.335(h)(1)(ii), 155.715(e) or (f), or notices issued in accordance with future guidance on exemptions pursuant to section 1311(d)(4)(H).

We propose the term "appellant" to mean the applicant or enrollee, the employer, or the small business employer or employee who is requesting an appeal.

We propose the term "de novo review" to mean a review of an appeal without deference to prior decisions in the case.

We propose the term "evidentiary hearing" to mean a hearing conducted where new evidence may be presented.

We propose the term "vacate" to mean to set aside a previous action.

We seek comment on these definitions.

24. General Eligibility Appeals Requirements (§155.505)

In §155.505, we propose the general eligibility appeals standards as well as the options for an Exchange to conduct eligibility appeals. In paragraph (a), we propose that, unless otherwise specified, the provisions of subpart F apply to Exchange eligibility appeals processes, regardless of whether the appeals process is provided by a state-based Exchange appeals entity or by HHS. We seek comment on this provision.

In paragraph (b), we propose to define the scope of those determinations that an applicant or enrollee may appeal, pursuant to §155.355 and forthcoming guidance on exemptions under section 1311(d)(4)(H) of the Affordable Care Act. Specifically, we propose that applicants and enrollees have the right to appeal eligibility determinations made in accordance with subpart D. This includes initial eligibility determinations made pursuant to §155.305(a) through (h) (eligibility for enrollment in a QHP, Medicaid, CHIP, and the BHP, if applicable, and for advance payments of the premium tax credit, and cost-sharing reductions as well as eligibility for QHP enrollment periods and eligibility for enrollment in a catastrophic plan), and redeterminations made pursuant to §§155.330 and 155.335. Applicants and enrollees may also

appeal the amount of advance payments of the premium tax credit and level of cost-sharing reductions for which they are eligible. In paragraph (b)(2), we propose that applicants and enrollees may appeal an eligibility determination for an exemption made in accordance with future guidance on exemptions pursuant to 1311(d)(4)(H) of the Affordable Care Act. Finally, in paragraph (b)(3), we propose that if the Exchange fails to provide timely notice of an eligibility determination or redetermination under §§155.310(g), 155.330(e)(1)(ii), or 155.335(h)(1)(ii), such failure is appealable. We seek comment on these provisions.

In paragraph (c), we propose the options for Exchange appeals. Specifically, we propose that final eligibility determinations, after exhaustion of any inconsistency period under §155.315(f), may be appealed through the Exchange appeals process, if the Exchange elects to establish such a process, or to HHS. In addition, pursuant to the requirements of section 1411(f)(1) of the Affordable Care Act, all Exchange appellants may have their appeal reviewed by HHS upon exhaustion of the Exchange appeals process. Thus, we expect that, where a state-based Exchange is operating and has established an appeals process, appellants will first appeal through the state-based process and then, if dissatisfied with the outcome, have the opportunity to elevate the appeal to the HHS appeals process. We anticipate that a state-based Exchange may elect to establish the appeals function within the Exchange or to authorize an eligible state entity to carry out the appeals function.

We anticipate that states will have an interest in adjudicating appeals of eligibility determinations made by their state-based Exchanges; therefore, we propose to provide flexibility for states to provide an appeals process while respecting the requirement in section 1411(f)(1) of the Affordable Care Act that a federal appeals process be available to appellants in the individual market. We seek comment on this provision.

In paragraph (d), we propose that appeals entities must comply with the standards set forth for providing fair hearings established by Medicaid at 42 CFR 431.10(c)(2). Meeting

Medicaid due process requirements is part of the minimum standard an entity must meet to be eligible to process Medicaid appeals, which we propose may be delegated to Exchange appeals entities. We seek comment on this provision.

In paragraph (e), we propose that an appellant may designate an authorized representative to act on his or her behalf, including making an appeal request, as provided in §155.227. We anticipate that many appellants will need to or will prefer to rely on an authorized representative to assist them with the appellate process. Such assistance and representation is common in other public benefit appeals processes and we seek to offer similar accommodation to Exchange appellants. We seek comment on this provision.

In paragraph (f), we propose that appeals processes must be accessible to appellants who are limited English proficient, or who are living with disabilities, consistent with the requirements in §§155.205(c). We solicit comments on this provision.

In paragraph (g), we propose that an appellant may seek judicial review to the extent allowable by law. We anticipate that some appellants may wish to pursue legal recourse beyond the administrative appeals proposed here. We seek comment on this provision.

25. Appeals Coordination (§155.510)

In §155.510, we propose the general coordination requirements for the appeals entities and the agencies administering insurance affordability programs. Similar to the flexibility offered to states in choosing an eligibility determination process, the corresponding flexibility for eligibility appeals can ensure that appeals are managed in a seamless, consumer-friendly manner.

In paragraph (a), we propose that the appeals entity or the Exchange must enter into agreements with the agencies administering insurance affordability programs regarding the appeals processes for such programs as are necessary to fulfill the requirements of this subpart. The agreements will clearly outline the responsibilities of each entity to support the eligibility

appeals process. In paragraph (a)(1), we propose the agreements must seek to minimize burden on appellants, including not requesting the appellant provide information previously provided in the process. However, we note that in the case where the appellant has provided information but the information cannot be located after a careful review of the appellant's file, including all information transmitted from other entities, we anticipate that it may be reasonable for the receiving entity to request the previously submitted documentation from the appellant. In paragraph (a)(2), we propose the agreements must ensure prompt issuance of appeal decisions. Finally, in paragraph (a)(3), we propose the agreements must comply with the coordination requirements established by Medicaid under 42 CFR §431.10(d). We seek comment on these provisions.

In paragraph (b), we propose coordination standards for Medicaid and CHIP appeals. In paragraph (b)(1), we propose that consistent with 42 CFR §431.10(c)(1)(ii) (the proposed Medicaid rule regarding delegations of authority to conduct fair hearings) and §457.1120, the appellant must be informed of the option to opt into pursuing his or her appeal of an adverse Medicaid or CHIP determination made by the Exchange directly with the Medicaid or CHIP agency, and if the appellant elects to do so, the appeals entity transmits the eligibility determination and all information provided via secure electronic interface, promptly and without undue delay, to the Medicaid or CHIP agency, as applicable. Our goal is to achieve a coordinated and integrated eligibility and appeals process that limits the burden on the appellant, the Exchange appeals entity, and the state Medicaid and CHIP agencies. The proposed regulatory language in paragraph (b)(1) provides a general requirement that the appellant be notified of the option to opt into appealing a Medicaid or CHIP denial to the Medicaid or CHIP agency rather than to the Exchange appeals entity. We are also considering a more specific requirement to align with the preamble proposed by Medicaid in which the appellant would be informed at the time of the eligibility determination made by the Exchange of his or her right to

opt into an appeal of the denial of Medicaid or CHIP eligibility with the state Medicaid or CHIP agency. Under this approach, we assume that most appellants will not opt into having his or her appeal heard by the Medicaid agency, which would result in two separate appeals (one before the Exchange appeals entity and one before the Medicaid or CHIP agency) and will instead choose to have both Medicaid or CHIP and Exchange-related issues heard before the Exchange appeal entity. If the Exchange appeals entity conducts the hearing on the Medicaid or CHIP denial that hearing decision would be final under the proposed rule. We seek comment on the proposed provision and the alternative for this proposed provision.

In paragraph (b)(2), we propose that where the Medicaid or CHIP agency has delegated appeals authority to the Exchange appeals entity consistent with 42 CFR §431.10(c)(1)(ii) and the appellant has elected to have the Exchange appeals entity hear the appeal, the appeals entity may include in the appeals decision a determination of Medicaid and CHIP eligibility. In addition, we propose in paragraph (b)(2)(i) that the appeals entity must apply MAGI-based income standards and standards for citizenship and immigration status using verification rules and procedures consistent with Medicaid and CHIP requirements under 42 CFR parts 435 and 457. In paragraph (b)(2)(ii), we propose that notices required in connection with an eligibility determination for Medicaid or CHIP be performed by the appeals entity consistent with standards set forth by this subpart, subpart D, and by the state Medicaid or CHIP agency, consistent with applicable law. We seek comment on these provisions.

In paragraph (b)(3), we propose that where a state Medicaid or CHIP agency has not delegated appeals authority to an appeals entity and the appellant seeks review of a denial of Medicaid or CHIP eligibility, the appeals entity must transmit the eligibility determination and all information provided as part of the appeal via secure electronic interface, promptly and without undue delay, to the Medicaid or CHIP agency, as applicable. We seek comment on this provision.

In paragraph (b)(4), we propose the Exchange must consider an appellant determined or assessed by the appeals entity as not potentially eligible for Medicaid or CHIP as ineligible for Medicaid and CHIP based on the applicable Medicaid and CHIP MAGI-based income standards for the purposes of determining eligibility for advance payments of the premium tax credit and cost-sharing reductions. We seek comment on this provision.

In paragraph (c), we propose that appeals entities must ensure that all data exchanges that are part of the appeals process comply with the requirements of §155.260, §155.270 and §155.345(h) and comply with all data sharing requests from HHS. We anticipate that appeals-related data will need to be passed between the Exchange, Medicaid, CHIP, and the state-based Exchange and HHS appeals entities in order to process appeal requests and implement appeal decisions. In addition, specific appeals-related information will be shared with the Internal Revenue Service via HHS in order to facilitate the tax reconciliation process under 26 CFR 1.36B-4.

We solicit comments on the provisions regarding appeals coordination between the Exchange, the appeals entities, and the Medicaid and CHIP agencies, where applicable.

25. Notice of Appeal Procedures (§155.515)

In paragraph (a) of this section, we propose that an Exchange must provide notice of appeal procedures at the time of the application and again when the eligibility determination notice is sent under §155.310(g), §155.330(e)(1)(ii), §155.335(h)(1)(ii), or future guidance on exemptions pursuant to §1311(d)(4)(H) of the Affordable Care Act. We anticipate that Exchanges can meet this requirement by including a reference to the appeals process in the single streamlined application required under §155.405 and in the eligibility determination notices required under §§155.310(g), 155.330(e)(1)(ii), and 155.335(h)(1)(ii) and future guidance on exemptions under section 1311(d)(4)(H) of the Affordable Care Act.

We also propose, in paragraph (b), the general content for notices on the right to appeal

and on appeal procedures. Specifically, we propose content including an explanation of the applicant or enrollee's appeal rights, procedures for requesting an appeal, right of representation, and an explanation of the circumstances under which eligibility may be maintained or reinstated pending an appeal. We note that the right of representation includes both legal counsel and authorized representatives. As defined in §155.227, an authorized representative can be anyone designated as such by the appellant. We also propose that notice content should include an explanation that the outcome of an appeal decision for one household member may result in a change in eligibility for other household members and that such a change may be handled as a redetermination in accordance with the standards specified in §155.305. We solicit comments on the proposed publication of appellate procedures.

27. Appeal Requests (§155.520)

In paragraph (a) of §155.520, we propose that the Exchange and the appeals entity must accept appeal requests submitted by telephone, via mail, in person (if the Exchange or appeals entity is capable of receiving in-person appeal requests), or via the Internet. We believe that this is the appropriate policy to propose in order to provide appellants greater flexibility and access to the process. We propose that the Exchange and the appeals entity may assist the applicant or enrollee in making the appeal request. In addition, we propose that the appeals entity must not limit or interfere with an applicant or enrollee's right to make an appeal request. Finally, we propose that an appeal request must be considered valid for the purposes of this subpart if it is submitted in accordance with the requirements of paragraphs (b) and (c) of this section and §155.505(b). We seek comment on these provisions.

In paragraph (b), we propose that the Exchange or appeals entity must allow an applicant or enrollee to request an appeal within 90 days of the date of the eligibility determination notice. In paragraph (c), we propose that appellants who disagree with a state-based Exchange appeals entity decision may appeal to HHS for further administrative review within 30 days of the date

of the state-based Exchange appeals entity's notice of appeal decision. We seek comment on these provisions.

In paragraph (d), we propose standards for acknowledging an appeal request. In paragraph (d)(1), we propose that upon receipt of a valid appeal request, the appeals entity must send timely acknowledgement to the appellant of the receipt of his or her valid appeal request, including information regarding the appellant's eligibility pending appeal pursuant to §155.525 and an explanation that any advance payments of the premium tax credit paid on behalf of the tax filer pending appeal are subject to reconciliation under 26 CFR §1.36B-4. We note that we use the term "tax filer" in this instance because the appellant may not be the household tax filer; therefore, the tax filer will be the recipient of the advance payments of the premium tax credit on behalf of the appellant. In paragraph (d)(1)(ii), we propose that the appeal entity must send timely notice via secure electronic interface of the appeal request and, if applicable, instructions to provide eligibility pending appeal pursuant to §155.525 to the Exchange and to the agencies administering Medicaid and CHIP, where applicable. We anticipate that this proposed standard will facilitate coordination between the appeals entity and the Exchange, Medicaid, and CHIP, where applicable, so that appellants who qualify for continuing eligibility during an appeal will not experience a gap in coverage. In paragraph (d)(1)(iii), we propose that if the appeal request is made pursuant to paragraph (c) of this section, the appeals entity must send timely notice via secure electronic interface of the appeal request to the state-based Exchange appeals entity. In paragraph (d)(1)(iv), we propose that the appeals entity must promptly confirm receipt of the records transferred pursuant to paragraph (d)(3) or (4) of this section to the Exchange or the state-based Exchange appeals entity, as applicable.

In paragraph (d)(2), we propose that, upon receipt of an appeal request that is not valid under §155.520 or §155.505(b), the appeals entity must, promptly and without undue delay, send written notice, either electronically or in hard copy, to the applicant or enrollee that the appeal

request has not been accepted and the reason why, so that the applicant or enrollee may have the opportunity to cure a defect in the appeal request. We propose that the appeals entity must accepted an amended appeal request that meets the requirements of §155.520 and §155.505(b), including standards for timeliness.

In paragraph (d)(3), we propose that, upon receipt of a valid appeal request pursuant to paragraph (b) of this section, or upon receipt of the notice under paragraph (d)(1)(ii) of this section, the Exchange must transmit via secure electronic interface to the appeals entity the appeal request, if the appeal request was initially made to the Exchange, and the appellant's eligibility record. Because we have provided flexibility for the appellant to request an appeal at the Exchange or at the appeals entity under §155.520(a), we anticipate that in some cases the Exchange will be the initial receiver of the appeal request and, therefore, must transmit this information to the appeals entity for review. However, regardless of whether the Exchange receives the appeal request first or is notified by the appeals entity of such a request, the Exchange must transmit the appellant's eligibility record to the appeals entity to use in the adjudication of the appeal. In paragraph (d)(4), we propose that upon receipt of the notice pursuant to paragraph (d)(1)(iii), the state-based Exchange appeals entity must transmit via secure electronic interface the appellant's appeal record, including the appellant's eligibility record as received from the Exchange, to HHS.

We seek comment on the appeal acknowledgement and notification provisions in §155.520(d).

28. Eligibility Pending Appeal (§155.525)

In §155.525, we propose the process by which an appellant may receive benefits while his or her appeal is pending in specific circumstances. In paragraph (a), we propose that upon receipt of a valid appeal request or notice under §155.520(d)(1)(ii) that concerns an appeal of a mid-year or annual redetermination, the Exchange, or the Medicaid or CHIP agency as

applicable, must continue to consider the appellant eligible while the appeal is pending in accordance with the standards in paragraph (b) or as determined by Medicaid or CHIP, as applicable, under 42 CFR parts 435 and 457. In paragraph (b), we propose that the Exchange must continue the appellant's eligibility for enrollment in a QHP, advance payments of the premium tax credit, and cost-sharing reductions, as applicable, in accordance with the level of eligibility immediately before the redetermination being appealed. For example, if the appellant had been eligible for advance payments of the premium tax credit in the previous coverage year but, upon annual redetermination, was denied advance payments of premium tax credit, the Exchange would consider the appellant eligible to continue to receive advance payments of premium tax credit at the level of the appellant's prior eligibility while the appeal is pending. As stated in subpart D of this part, receipt of advance payments of the premium tax credit may be waived by the tax filer. In addition, the continued receipt of advance payments of the premium tax credit during the appeal may impact the amount owed or due at the IRS reconciliation process, depending upon the appeal decision.

As is standard in many public programs, including Medicaid and the private market, we propose that a continuation of benefits should be available to individuals already enrolled in coverage while appealing a change in current eligibility. This approach ensures continuity of coverage and care during an appeal as well as minimizes the impact of eligibility errors on beneficiaries. Eligibility pending appeal will not be offered to appellants who are appealing their initial denial of eligibility because of the unique challenges in identifying the appropriate pended benefit (if any) for such an appellant. It should be noted that while applicants and enrollees may receive coverage during the inconsistency period prior to receiving their final redetermination, as set forth in §155.315, coverage during this period is based on a different standard than eligibility received while an appeal is pending. Specifically, under §§155.315(f)(4)(i) and (ii), an applicant or enrollee in an inconsistency period receives the eligibility based on the information to which

he or she attested. However, we propose that during an appeal, qualified appellants receive eligibility that corresponds to that which they had immediately before the redetermination being appealed. Because of the differences in calculating eligibility during these two processes, we anticipate that an individual who appeals a redetermination following an inconsistency period may not receive the same eligibility during the appeal as during the inconsistency period. Finally, we note that for an applicant who receives an initial eligibility determination that is not a denial and requests an appeal, he or she will receive eligibility per the original determination during the course of his or her appeal. We solicit comments on the proposed approach, including our proposal to not pend benefits to new applicants who are denied eligibility.

29. Dismissals (§155.530)

In paragraph (a) of §155.530, we propose the circumstances under which an appeals entity must dismiss the appeal. We propose paragraphs (1) through (4) that the appeals entity must dismiss an appeal if the appellant withdraws the appeal request in writing, either electronically or in hard copy; fails to appear at a scheduled hearing; fails to submit a valid appeal request as defined in §155.520(a)(4); or dies while the appeal is pending. We note that paragraph (a)(4) is only intended to exclude those appeal requests which fail to meet timeliness standards or are clearly requesting an appeal for something unrelated to the eligibility determinations relevant to this subpart. This provision is not intended to exclude appeal requests that may have other minor deficiencies or are submitted without complete information. In paragraph (b), we propose that an appellant whose appeal is dismissed must be provided a timely notice by the appeals entity that includes the reason for dismissal, an explanation of the dismissal's effect on the appellant's eligibility, and an explanation of how the appellant may show good cause why the dismissal should be vacated in accordance with paragraph (d) of this section. In paragraph (c), we propose that, if an appeal is dismissed, the appeals entity must provide timely notice to the Exchange and to the agency administering Medicaid or CHIP, as

applicable, which must include instructions regarding the appropriate eligibility determination to implement and the discontinuation of pended eligibility provided under §155.525. Finally, in paragraph (d), we that propose the appeals entity may vacate a dismissal if the appellant makes a written request, either electronically or in hard copy, within 30 days of the date of the notice of dismissal, showing good cause why the dismissal should be vacated. The option for the appeals entity to vacate dismissals allows for programmatic flexibility. For example, if the appellant can prove that he or she was incapacitated and therefore could not attend his or her scheduled hearing, the appeals entity may vacate a dismissal that was based upon the appellant's failure to appear at a scheduled hearing. We solicit comments on the proposed approach for appeal dismissals and vacating an appeal dismissal.

30. Informal Resolution and Hearing Requirements (§155.535)

In §155.535, we propose standards for adjudicating eligibility appeals. We provide the option for informal resolution of appeals as well as hearings. In paragraph (a), we propose that the HHS appeals process will provide an opportunity for informal resolution and a hearing, and that a state-based Exchange appeals entity may also provide an informal resolution process prior to a hearing. We anticipate that this process will provide appellants the opportunity to work with appeals staff to try to resolve the appeal pre-hearing through a review of case documents, verification of the accuracy of submitted documents, and the opportunity for the appellant to submit updated information or provide further explanation of previously submitted documents. Although this subpart does not require state-based Exchange appeals entities to provide an informal resolution process, HHS will provide an informal resolution process to all appellants who use the HHS appeals process.

In paragraph (a), we propose that informal resolution will be offered to appellants in the HHS appeals process, and may be offered to appellants in a state-based Exchange appeals process, provided that the process is limited in scope to what would be considered at hearing,

including the information used to determine the appellant's eligibility as well as any additional relevant evidence provided by the appellant during the course of the appeal. In addition, the provision of, or an appellant's participation in, an informal resolution process must not impair the appellant's right to hearing, where the appellant remains dissatisfied with the outcome of the informal resolution process. We consider that the appellant is in the best position to determine whether he or she is satisfied with the outcome of an informal resolution and, therefore, must be afforded a hearing if he or she is dissatisfied with the outcome of the informal resolution process. For example, an appellant may continue to be dissatisfied with the level of advance payments of the premium tax credits for which he or she is determined eligible following informal resolution and seek to pursue the issue at hearing. Furthermore, this parallels the Medicaid fair hearing requirement that an appellant must be provided a hearing where he or she believes the agency has taken an erroneous action. We also propose that an appeals entity whose process includes an informal resolution component must minimize the burden on the appellant by not requesting that he or she provide duplicative information at various stages of appeal. We expect a significant portion of appeals may be resolved through informal resolution. For example, some applicants will fail to submit all required information or documentation during the application process (or information or documentation submitted will not be verified), and will fail to rectify this during the statutory inconsistency period, but will present such information during an appeal. However, some appellants will remain dissatisfied with the eligibility determination that results from the informal resolution process, and these appellants must be afforded the opportunity for a hearing. We note that unless an appellant requests a hearing, the decision reached through informal resolution by the appeals entity is considered final and binding.

In paragraph (b), we propose that when a hearing is scheduled the appeals entity must send written notice, electronically or in hard copy, to the appellant of the date, time, and location or format of the hearing no later than 15 days prior to the date of hearing. We anticipate that 15

days will provide the appellant enough time to contact the appeals entity if the date and time are prohibitive of participation. If the appellant informs the appeals entity that the designated date and time are prohibitive of participation, we expect that the appeals entity will work with the appellant to set a reasonable and mutually convenient date and time. In addition, the format of a hearing encompasses telephonic hearings and hearings held by video teleconference. Again, if an appeal is resolved to the appellant's satisfaction through informal resolution, a hearing will not be necessary and will not need to be scheduled. We do not expect the appeals entity to schedule a hearing until the appellant has indicated that he or she is dissatisfied with the outcome of the informal resolution process, if such a process is in place; however, if the appeals entity does not provide an informal resolution process, we expect that the appeals entity will schedule a hearing upon receipt of the appeal request.

In paragraph (c), we propose requirements for conducting hearings, including that hearings must be conducted at a reasonable date, time, and location or format; after notice of the hearing has been issued to the appellant; as an evidentiary hearing where appellants may present evidence; and by one or more impartial officials who have not been directly involved in the eligibility determination or any prior Exchange appeal decision in the same matter. These requirements are modeled off Medicaid's fair hearing requirements and aim to provide the appellant with sufficient notice and opportunity to participate in the hearing as well as ensure the hearing decision is issued by an impartial hearing officer.

In paragraph (d), we propose the procedural rights afforded to an appellant. These rights are based on those provided in Medicaid fair hearings under 42 CFR §431.242. In paragraph (d)(1), we propose that the appeals entity must provide the appellant with the opportunity to review his or her appeal record and all the documents to be used by the appeals entity at the hearing, at a reasonable time before the date of the hearing as well as during the hearing. In paragraph (d)(2), we propose that the appellant have the ability to bring witnesses to testify. In

paragraph (d)(3), we propose that the appellant have the opportunity to establish all relevant facts and circumstances. In paragraph, (d)(4), we propose that the appellant may present arguments without undue interference. Finally, in paragraph (d)(5), we propose that the appellant may question or refute any testimony or evidence, including the opportunity to confront and cross-examine adverse witnesses. Although we have included the ability to cross-examine adverse witnesses, we anticipate that most hearings will be held in a non-adversarial manner without an adverse party or representative from the agency determining eligibility present during appeal. However, we understand that eligibility representatives are occasionally part of Medicaid fair hearings, and we do not want to foreclose the possibility of cross examination for such cases where an adverse witness is present. The procedural rights we outline correspond to those afforded to Medicaid appellants.

In paragraph (e), we propose that the appeals entity must consider the information used to determine the appellant's eligibility and any relevant evidence presented during the course of the appeal, including at the hearing. This provision will allow the appellant to bring forward information at multiple points in the process. We seek comment on this provision.

In paragraph (f), we propose that the appeals entity review appeals de novo. We consider this standard of review critical to allow the appellant the opportunity for a fresh review at each stage of appeal and the opportunity to bring new relevant evidence throughout the process.

We seek comment on our informal resolution and hearing requirements and standards.

31. Expedited Appeals (§155.540)

In §155.540, we propose the standards for expedited appeals. In paragraph (a), we propose that the appeals entity must establish and maintain an expedited appeals process for an appellant to request an expedited process where there is an immediate need for health services because a standard appeal could seriously jeopardize the appellant's life or health or ability to attain, maintain, or regain maximum function. In paragraph (b), we propose that if an appeal

entity denies a request for an expedited appeal, it must handle the appeal under the standard process and issue the appeal decision in accordance with §155.545(b)(1) and make reasonable efforts to inform the appellant through electronic or oral notification of the denial and, if notified orally, follow up with the appellant by written notice, either electronically or in hard copy, within two days of the denial. The standards proposed for expedited appeals parallel those contained in the proposed Medicaid regulations in this proposed rule at §431.224 and §431.244. We seek comment on this provision and the timelines associated with it.

32. Appeal Decisions (§155.545)

In section 155.545, we propose requirements for the content and issuance of appeal decisions. In paragraph (a)(1), we propose that appeal decisions be based exclusively on the application of the eligibility rules established in subpart D of this part or pursuant to future guidance on section 1311(d)(4)(H) of the Affordable Care Act, as applicable, to the information used to make the eligibility determination as well as any relevant evidence provided by the appellant during the course of the appeal. In paragraphs (a)(2) through (a)(5), we propose that the content of the appeal decision must include the decision with a plain language description of the effect of the decision on the appellant's eligibility, a summary of the facts relevant to the appeal, an identification of the legal basis for the decision, and the effective date of the decision. The above requirements are based on Medicaid's fair hearing standards, and we intend each piece to assist the appellant in understanding how the eligibility standards, applied to the facts of his or her case, resulted in the appeal decision.

Finally, in paragraph (a)(6), we propose that, if the appeals entity is a state-based Exchange appeals entity, the appeal decision must include an explanation of the appellant's right to pursue an appeal at HHS if the appellant remains dissatisfied with the post-hearing eligibility determination. We seek comment on these provisions for the appeal decision.

In paragraph (b)(1), we propose the standards for the appeals entity to issue written notice of the appeal decision, either electronically or in hard copy, to the appellant. We propose that such notice to the appellant be issued within 90 days of the date an appeal request under §155.520(b) or (c) is received, as administratively feasible. We anticipate the appeals entity may, at times, experience significant increases in appeals volume, such as during open enrollment or high-volume redetermination periods, and may also require additional time due to coordination requirements with Medicaid and other agencies and appeals entities. In paragraph (b)(2), we propose that, in the case of an appeal request submitted under §155.540 that the appeals entity determines meets the criteria for an expedited appeal, the appeals entity must issue notice of the appeal decision as expeditiously as the appellant's health condition requires, but no later than three working days after the appeals entity receives the request for an expedited appeal. Finally, in paragraph (b)(3), we propose that the appeals entity send notice of the appeal decision via secure electronic interface to the Exchange or the Medicaid or CHIP agency, as applicable. This notice requirement seeks to connect the appeals decision with the entity responsible for implementing the appeal decision. In addition, the Exchange or the Medicaid or CHIP agency, as applicable, will need to be notified that the appellant no longer should receive pended eligibility. We seek comment on these proposed appeal decision notice requirements.

In paragraph (c), we propose that the Exchange or the Medicaid or CHIP agency, as applicable, must promptly implement appeal decisions upon receiving the notice described in paragraph (b). In paragraph (c)(1), we propose that the effective dates of the changes resulting from an appeal correspond with existing timeframes established under §155.330(f) or, where applicable, retroactively to the eligibility determination date that was the subject of the appeal, or in accordance with standards set forth by Medicaid or CHIP, in 42 CFR parts 435 or 457, as applicable. The purpose of an appeal is to ensure that the appellant receives the appropriate benefit determination. Therefore, appeal decisions that overturn the original eligibility

determination commonly seek to "right the wrong" by making the appellant whole, which we believe includes retroactive eligibility. In the Medicaid context (as with the majority of public benefit programs), 42 CFR §431.246 directs state agencies to "promptly make corrective payments, retroactive to the date an incorrect action was taken."

We seek comment regarding the operational considerations associated with retroactive eligibility as a result of an appeal, and whether potential operational difficulties, if any, could be alleviated by limiting the policy on retroactive eligibility. For example, we considered limiting retroactive eligibility to those already enrolled in coverage. In addition, we note that an individual who is not enrolled and receives retroactive eligibility could always choose not to enroll retroactively. We believe this choice might be desirable if an appellant did not wish to obtain the retroactive coverage, which could involve the payment of premiums. We also considered specifically limiting the scope of retroactive eligibility with respect to advance payments of the premium tax credit or cost-sharing reductions, consistent with our approach in 155.330(f)(2)-(7). Finally, we note that the inconsistency period under §155.315(f) may mitigate many of these operational concerns by allowing the resolution of eligibility issues pre-appeal. We seek comment on the retroactive implementation of appeal decisions, and specifically on whether the ability to enroll in coverage retroactively should be optional or limited, and if so, in what way.

In paragraph (c)(2), we propose that the Exchange or the Medicaid or CHIP agency, as applicable, must promptly redetermine the eligibility of other members of the appellant's household who have not appealed their own eligibility determinations but whose eligibility may be affected by the appeal decision, in accordance with the standards specified in §155.305. We anticipate that evidence received during the course of an appeal, for example updated income information, may indicate that a redetermination is required for household members who have not appealed their own eligibility determinations. For such household members, the Exchange,

or the Medicaid or CHIP agency, as applicable, must undertake a redetermination. We seek comment on these provisions.

33. Appeal Record (§155.550)

In §155.550, we propose requirements for accessing the appeal record. In paragraph (a), we propose the appeal record be made accessible to the appellant at a convenient place and time subject to the requirements of all applicable federal and state laws regarding privacy, confidentiality, disclosure, and personally identifiable information. In paragraph (b), we propose the appeals entity must provide public access to all appeal records, subject to all applicable federal and state laws regarding privacy, confidentiality, disclosure, and personally identifiable information. The requirement for access to the appeal record by the appellant corresponds to a similar Medicaid fair hearing requirements under 42 CFR §431.244(c) and §431.244(g). We seek comment on this provision.

34. Employer Appeals Process (§155.555)

In paragraph (a), pursuant to section 1411(f)(2) of the Affordable Care Act, we propose that an appeals process shall be established through which an employer may appeal, in response to a notice under §155.310(h) regarding an employer's potential tax liability, a determination that the employer does not provide minimum essential coverage through an employer-sponsored plan or that the employer does provide such coverage but it is not affordable coverage with respect to the employee referenced in the notice. We note that the employer appeal is the opportunity for the employer to correct any information the Exchange received from an employee's application regarding the employer's offering of coverage. The appeals entity is responsible for a de novo review of whether the employer's offer of coverage is sufficient such that the employee at issue is not entitled to advance payments of the premium tax credit or other cost-sharing reductions under section 1402.

The employer appeals process is separate and distinct from the IRS's process determining

whether an employer is liable for a tax penalty under section 4980H of the Code and any appeal rights the employer may have under subtitle F of the Code. We anticipate that some employers will receive a notice of potential tax liability from the Exchange even though the employer may not in fact have any tax liability under section 4980H. For example, notices under §155.310(h) must be issued to employers without regard to their size, yet tax liability under section 4980H arises only against applicable large employers, that is, generally, those employers with more than 50 full-time equivalent employees. Our goal is to work closely with the IRS to educate and develop notices that help employers understand their potential tax liabilities and the consequences of a successful appeal. We seek comment on these provisions.

In paragraph (b), we propose that Exchanges have the flexibility to establish an employer appeals process in accordance with the requirements of §155.505(e) through (g), and §155.510(a)(1), (a)(2), and (c). We further propose that, where an Exchange has not established an employer appeals process, HHS will provide an employer appeals process that meets the requirements of this section, §155.505(e) through (g), and §155.510(a)(1), (a)(2), and (c).

In paragraph (c), we propose the process and standards for requesting an appeal. In paragraph (c)(1), we propose that an Exchange or appeals entity must allow an employer to request an appeal within 90 days from the date of the notice of the employee's eligibility for advance payments of the premium tax credit or cost-sharing reductions is sent. In paragraph (c)(2), we propose that the Exchange or appeals entity must allow an employer to submit relevant evidence to support the appeal request. We anticipate only a limited set of evidence (information already possessed by the employer) will be relevant to this appeal. For example, employers might submit information pertaining to whether coverage is offered by the employer, whether the employee has taken up such coverage, the employee's portion of the lowest cost plan offered, and whether or not the employee is in fact employed by the employer. In paragraph (c)(3), we propose that an Exchange or appeals entity must allow an employer to submit an

appeal request to the Exchange or the state-based Exchange appeals entity, if the Exchange establishes an employer appeals process, or to HHS, if the Exchange does not offer an employer appeals process. This option for filing an appeal request reflects the flexibility described in paragraph (b) of this section that states have to establish an employer appeal process. In addition, unlike the appeals process for individual eligibility determinations, section 1411(f)(2) of the Affordable Care Act does not require employer appeals to be reviewed by a federal officer; therefore, an employer does not have the right to elevate an appeal decision made by a state-based Exchange appeals entity to HHS. However, employer appeals may be appealed to HHS where no appeals process is established by the Exchange for employers. We seek comment on these provisions.

In paragraph (c)(4), we propose that the Exchange and the appeals entity must comply with the requirements of §155.520(a)(1) through (3), such that an employer appeal may be submitted by telephone, mail, in person where available, or by Internet, and the appeals entity may assist the employer with making the appeal request and must not limit or interfere with the employer's right to request an appeal. We seek comment on these provisions.

In paragraph (c)(5), we propose that an appeals entity must consider an appeal request valid if it is submitted within 90 days of the notice to the employer of a determination that the employer does not provide minimum essential coverage through am employer-sponsored plan or that the employer does provide that coverage but it is not affordable coverage with respect to an employee. We seek comment on this provision.

We propose in paragraph (d)(1) that, upon receipt of a valid appeal request, the appeals entity must send timely acknowledgement of the receipt of the appeal request to the employer, including an explanation of the appeals process. We propose in paragraph (d)(2), that, upon receipt of a valid appeal request, the appeals entity must send notice of the request to the employee, including an explanation of the appeals process, instructions for submitting additional

evidence for consideration by the appeals entity, and an explanation of the potential effect of the employer's appeal on the employee's eligibility. We anticipate that the notice to the employee under paragraph (d)(2) will be the primary means through which the employee will learn about the employer's appeal. Just as the employer will have the opportunity to submit information in support of the appeal to the appeals entity, the employee's notice will describe the employee's opportunity to participate in the employer appeal process Furthermore, we note that the explanation of the potential effect of the employer's appeal on the employee's eligibility proposed in (d)(2)(iii) must explain that the employer appeal process may result in a redetermination that the employee is not eligible for advance payments of the premium tax credit or cost sharing reductions. For example, a redetermination may occur if the employee attested that he or she was not offered employer sponsored coverage but the employer establishes the offering of coverage through the appeal; the employee would be redetermined as ineligible for advance payments of the premium tax credit and cost sharing reductions.

In paragraph (d)(3), we propose that the appeals entity must promptly notify the Exchange of the employers' appeal request, if the employer did not initially make the appeal request to the Exchange. In paragraph (d)(4), we propose that, upon receipt of an appeal request that is not valid under the same section, the appeals entity must, promptly and without undue delay, send written notice, either electronically or in hard copy, to the employer that the appeal request has not been accepted and the reason why, so that the employer may have the opportunity to cure a defect in the appeal request. We propose that the appeals entity must accept an amended appeal request that meets the requirements of the same section, including standards for timeliness. We seek comment on these provisions.

In paragraph (e), we propose that upon receipt of a valid appeal request or the notice described in paragraph (d)(3) of the same section, the Exchange must promptly transmit via secure electronic interface the employee's eligibility record and the appeals entity must also

promptly confirm receipt of the records transferred by the Exchange. We did not propose specified timelines for "promptly" within this section and seek comment on these provisions, including on appropriate standards for promptness in this context.

In paragraph (f), we propose the process for the dismissal of an employer appeal. In paragraph (f)(1), we propose that the appeals entity must dismiss an appeal under the circumstances described in §155.530(a)(1) or if the request fails to comply with the standards in paragraph (c)(4) of this section. Specifically, this standard requires dismissal where the employer withdraws the request in writing, either electronically or in hard copy, or fails to submit a valid appeal request. We note that paragraph (f)(1) is only intended to exclude those appeal requests which fail to meet timeliness standards or are clearly requesting an appeal for something unrelated to the employer determination relevant to this section. This provision is not intended to exclude appeal requests that may have other minor deficiencies or are submitted without complete information. In paragraph (f)(2), we propose that the appeals entity must provide timely notice of the dismissal to the employer, employee, and Exchange, including the reason for dismissal. In paragraph (f)(3), we propose that the appeals entity may vacate a dismissal if the employer makes a written request, either electronically or in hard copy, within 30 days of the date of the notice of dismissal showing good cause why the dismissal should be vacated. We seek comment on the provisions regarding dismissal and vacatur of a dismissal.

In paragraph (g), we propose the procedural rights of the employer requesting the appeal. In paragraph (g)(1), we propose that the employer must have the opportunity to provide relevant evidence to the appeals entity for review as part of the appeal. In paragraph (g)(2), we propose that the employer must be able to review the information included in the statute and described in §155.310(h) and 26 CFR §1.36B, which includes the identity of the employee, information regarding whether the employee has been determined eligible for advance payments of the premium tax credit, and an explanation that the employer may be liable for the payment assessed

under section 4980(H) of the Code. In addition, the employer may request information regarding whether the employee's income is above or below the threshold by which the affordability of employer-sponsored minimum essential coverage is measured. Finally, the employer may have access to other data used to determine the employee's eligibility to the extent allowable by law, except the information described in paragraph (h) of this section. We seek comment on these proposed procedural rights.

We propose in paragraph (h) that neither the Exchange nor the appeals entity may make available to an employer any tax return information with respect to an employee in relation to his or her eligibility for advance payments of the premium tax credit or cost sharing reductions. We seek comment on the employers' right to review data and information used to make the employee's eligibility determination.

In paragraph (i), we propose the process and standards for adjudication of employer appeals. Specifically, we propose that the appeal must be reviewed by one or more impartial officials not directly involved in the employee eligibility determination implicated in the appeal, and that the appeal must include consideration of the information used to determine the employee's eligibility as well as any additional relevant evidence provided by the employer or the employee during the course of the appeal. Additionally, we propose that the appeal be reviewed de novo. We seek comment on this proposed approach.

In paragraph (j), we propose the standards for employer appeal decisions. Specifically, we propose that the appeal decision must be based exclusively on the information used to determine the employee's eligibility as well as any relevant evidence provided by the employer or the employee during the course of the appeal, and on the standards for an employer to provide minimum essential coverage that meets both affordability and minimum value standards through an employer-sponsored plan as stated in 45 CFR part 155, subpart D. Additionally, we propose that the appeal decision must state the decision, including a plain language description of the

effect of the decision on the employee's eligibility, and must comply with the requirements of §155.545(a)(3) through (5). We seek comment on the proposed approach.

In paragraph (k), we propose the requirements for the content and issuance of the notice of the employer appeal decision. We propose that the appeals entity must provide written notice, electronically or in hard copy, of the appeal decision within 90 days of the date the appeal request is received, as administratively feasible, to the employer, employee, and the Exchange. In paragraph (k)(1), we propose the employer's notice must include the appeal decision and an explanation that the appeal decision does not foreclose any appeal rights the employer may have under subtitle F of the Code. In paragraph (k)(2), we propose the employee's notice must include the appeal decision. Lastly, in paragraph (k)(3), we propose the appeals entity must provide written notice of the appeal decision, either electronically or in hard copy, to the Exchange. We seek comment on the proposed content of and timelines for issuing the notice of appeal decision.

In paragraph (l), we propose the requirements for implementation of the appeal decision. We propose that, after receipt of the notice under paragraph (k)(3) of this section, if the appeal decision affects the employee's eligibility, the Exchange must promptly redetermine the employee's eligibility in accordance with the standards specified in §155.305. We are considering, and we solicit comments on, two alternative options regarding whether the employee may appeal the results from this redetermination. Under the first option, the employee would be permitted to appeal a change in eligibility reflected in the redetermination notice generated after an employer appeal. However, if the employee were subsequently determined to be eligible for advance payments of the premium tax credit or cost-sharing reductions as a result of such an appeal, the employer would not be able to again appeal that determination to the Exchange. We believe that this approach would protect the interests of both the employee, whose appeal rights are determined by section 1411(f)(1) of the Affordable Care Act, and the

employer, whose appeal rights are determined by section 1411(f)(2). Although the employer would not have the option to appeal to the Exchange a second time, this would not foreclose any appeal rights still available under subtitle F of the Code.

Under the second option, the employee would not be permitted to appeal a change in eligibility reflected in the redetermination notice generated after an employer appeal. Instead, the employee would be issued a redetermination notice under this section which would not be appealable under §155.505(b)(1)(ii). For example, if the employer were able to establish during the appeal that it does provide coverage that is both affordable and meets minimum value standards, the employee would be redetermined as ineligible for advance payments of the premium tax credit and cost-sharing reductions. Because the redetermination would be the result of an employer appeal under this section, the employee would not have the appeal rights associated with redetermination notices, generally. However, under this option, the employee's interests would be protected by the opportunity to submit information to support his or her eligibility determination during the employer's appeal. Moreover, if the employee's circumstances were to change following the employer appeal decision and redetermination notice, the employee could submit information to the Exchange as a mid-year update under §155.330 and any resulting redetermination would be appealable.

We believe that either of these two approaches would be effective in limiting recurring appeals among the employee and employer. We seek comment on paragraph (l) and, specifically, on the two alternative options discussed above.

In paragraph (m), we propose that the appeal record be accessible to the employer and the employee in a convenient format and at a convenient time in accordance all applicable laws regarding privacy, confidentiality, disclosure, and personally identifiable information and the prohibition on sharing confidential employee information in paragraph (h) of this section. We seek comment on paragraph (m).

35. Functions of a SHOP (§155.705)

In accordance with the Secretary's authority in section 1321(A)(1)(A) of the Affordable Care Act to establish standards related to requirements of the Exchange and the SHOP Exchange, we propose standards for the SHOP to coordinate with the functions of the individual market Exchange for determining eligibility for insurance affordability programs. In paragraph (c) we specify that the SHOP will provide data to the individual market Exchange that corresponds to the service area in which the SHOP is operating related to eligibility and enrollment for a qualified employee, that is, an employee who is enrolled in a QHP through the SHOP or is eligible to enroll in coverage through a SHOP because of an offer of coverage from a qualified employer. We propose these standards to ensure that the Exchange can use SHOP data for purposes of verifying enrollment in an eligible employer-sponsored plan and eligibility for qualifying coverage in an eligible employer-sponsored plan as specified in §155.320(d). We expect that this will not create significant administrative burden since the SHOP and individual market Exchange may share core information technology systems and other supporting functionality. We note that like all information collected or maintained by the individual market Exchange or SHOP, this information is subject to the privacy and security standards of 45 CFR 155.260. We seek comment on the feasibility of sharing this data and the usefulness of this data in determining eligibility for advance payments of the premium tax credit and cost-sharing reductions.

36. SHOP Employer and Employee Eligibility Appeals (§155.740)

We propose to amend subpart H by adding proposed §155.740 to define the standards for SHOP employer and employee eligibility appeals, pursuant to our broad authority to establish standards for operating SHOP Exchanges under section 1321(a)(1)(A) of the Affordable Care Act. Although not expressly required by the Affordable Care Act, we believe that SHOP

employers and employees should have the opportunity to appeal determinations of ineligibility to participate in the SHOP.

In paragraph (a), we propose applying the definitions in §155.20, §155.300, and §155.500 to this section.

In paragraph (b), we propose the general requirements for establishing a SHOP appeals process for both employer and employee eligibility. First, in paragraph (b)(1), we propose that a state, establishing an Exchange pursuant to §155.100 must provide an eligibility appeals process for the SHOP. Because the SHOP was designed with flexibility to meet the individual needs of states, we anticipate that each SHOP will be in the best position to adjudicate SHOP eligibility appeals. The SHOP eligibility standards allow for a state to require additional verification before providing the employer or employee with an eligibility determination. We propose that, where a state has not established an Exchange pursuant to §155.100, HHS will provide an eligibility appeals process for the SHOP. In paragraph (b)(2), we propose that SHOP appeals entities comply with the requirements set forth in this section; §155.505(e) through (g); and §155.510(a)(1)-(2) and (c). We seek comment on these provisions.

In paragraph (c), we propose that an employer may appeal a notice of denial of eligibility under §155.715(e), or the failure of the SHOP to make an eligibility determination in a timely manner.

In paragraph (d), we propose an employee may appeal a notice of denial of eligibility under §155.715(f), or a failure of the SHOP to make an eligibility determination in a timely manner. We note that, although the employer has the option to provide information during an employee appeal (as stated below in paragraph (g) of this section), the employer is not required to participate in an employee's appeal and need not submit additional information beyond what the employer submitted at the time of application.

In paragraph (e), we propose that the SHOP provide notice of the employer or employee's right to appeal a determination of denial of eligibility in the written notice of eligibility provided under §155.715(e) or (f). We propose in paragraph (e)(1) that notice of this right must include the reason for the denial of eligibility along with a citation to the applicable regulations. In paragraph (e)(2), we propose that the notice must also include an explanation of the procedure by which the employer or the employee may request an appeal of the denial of eligibility. We seek comment on these provisions.

In paragraph (f), we propose the standards through which a SHOP appeal may be requested. In paragraph (f)(1), we propose the SHOP and appeals entity allow an employer or employee a 90-day window from the date of the notice of the denial of eligibility to request an appeal. Because the eligibility criteria for the SHOP are minimal and straightforward, we believe that 90 days to request an appeal provides ample time for an employer or employee to review the determination, gather any evidence that he or she may want considered in the appeal, and submit the appeal. In addition, we propose in (f)(1)(i) that employers and employees may submit their appeal requests to the SHOP or directly to the SHOP appeals entity established by the Exchange. In (f)(1)(ii), we propose that where a state has not established an Exchange, employers and employees may submit appeal requests to HHS. We seek comment on this timeframe.

In paragraph (f)(2), we propose that the SHOP and appeals entity accept appeal requests made by telephone, by mail, in person where available, or via the Internet. This requirement mirrors the methods to request an appeal in the individual market as provided in §155.520(a)(1). We seek comment on these appeal request methods.

In paragraph (f)(3), we propose that the SHOP and appeals entity comply with the requirements of §155.520(a)(2)-(3), which state that the SHOP or appeals entity may assist the employer or employee with the submission and processing of the appeal request and must not

limit or interfere with an employer or employee's right to request an appeal. These provisions ensure the accessibility of the process and prohibit appeals entities from dissuading an employer or employee who wishes to pursue the appeal rights provided under this section. We seek comment on these provisions.

In paragraph (f)(4), we propose that the SHOP and appeals entity must consider an appeal request valid if it is submitted within the 90-day timeframe described in paragraph (f)(1) of this section. We propose these requirements so that an appeals entity may dismiss appeal requests that do not meet these baseline standards. We seek comment on this provision.

We propose in paragraph (g)(1) that upon receipt of a valid appeal request, the appeals entity must send timely acknowledgement to the employer, or the employer and employee if an employee is appealing, of the receipt of the appeal request, including an explanation of the appeals process as well as instructions for submitting additional evidence for consideration by the appeals entity. In the case of an appeal by an employee, the employer may be able to take action to facilitate the employee's eligibility for coverage through the SHOP; accordingly, we propose to require that employers be notified of employee appeals so that employers may assess whether action on their part would be helpful. However, we note that the employer is not required to participate in the employee's appeal and need not submit additional information for an employee's appeal beyond what the employer submitted at the time of application. In paragraph (g)(2), we propose that the appeals entity must promptly notify the SHOP of the appeal, if the appeal request was not initially made to the SHOP. In paragraph (g)(3), we propose to require that the appeals entity must promptly and without undue delay, notify the employer or employee in writing upon receipt of an invalid appeal request, so that the employer or employee may have an opportunity to cure the defect, and the appeals entity must treat as valid an amended appeal request meeting all applicable requirements. We seek comment on these provisions.

In paragraph (h), we propose that upon receipt of a valid appeal request or the notice described in paragraph (g)(2) of the same section, the SHOP must promptly transmit via secure electronic interface to the appeals entity the appeal request and the eligibility record of the employer or employee that is appealing, and the appeals entity must also promptly confirm receipt of the records transferred by the SHOP. We did not propose specified timelines for "promptly" within this section and seek comment on the timelines standard in paragraph (h).

In paragraph (i), we propose the standards for the dismissal of an appeal request. In paragraph (i)(1)(i), we propose that the appeals entity must dismiss an appeal if the employer or employee that is appealing, or the employer or employee's authorized representative, withdraws the request in writing, either electronically or in hard copy. In paragraph (i)(1)(ii), we propose that the appeals entity must dismiss an appeal if the request does not meet the standards for a valid appeal outlined in paragraph (f)(4). We note that paragraph (f)(4) is only intended to exclude those appeal requests which fail to meet timeliness standards or are clearly requesting an appeal for something unrelated to SHOP eligibility determinations. This provision is not intended to exclude appeal requests that may have other minor deficiencies or are submitted without complete information. In paragraph (i)(2), we propose that the appeals entity must provide timely notice of a dismissal to the employer or employee that is appealing, including the reason for the dismissal, and must notify the SHOP of the dismissal. Finally, in paragraph (i)(3), we propose that the appeals entity may vacate a dismissal if the employer or employee demonstrates good cause to overturn the dismissal in writing within 30 days of the date of the notice of dismissal. We seek comment on these provisions and timeframes.

In paragraph (j), we propose the procedural rights of a SHOP appellant; specifically, we propose that the employer, or the employer and employee if an employee is appealing, must have the opportunity to submit relevant evidence for review of the eligibility determination by the appeals entity as part of a desk review. We anticipate that eligibility for SHOP participation can

be proven through documentary evidence. The proposed approach differs from the individual market because of the less complex nature of the SHOP eligibility criteria. We seek comment on this approach.

In paragraph (k), we propose the requirements for adjudicating a SHOP appeal. In paragraph (k)(1), we state that the appeal must comply with the requirements proposed in §155.555(i)(1) and (3), which state that an appeal must be reviewed by an impartial official who has not been directly involved in the eligibility determination subject to the appeal, and that appeals must be reviewed de novo. In paragraph (k)(2), we propose that the information considered in the appeal include the information used to determine the employer or employee's eligibility as well as any additional relevant evidence submitted during the appeal by the employer or employee. We intend this provision to allow employers and employees to submit evidence in support of their own appeal as well as allowing an employer to submit evidence during an employee's appeal. We seek comment on these provisions.

In paragraph (l), we propose SHOP appeal decision standards. In paragraph (l)(1), we propose that the appeal decision must be based solely on the evidence referenced in paragraph (k)(2) of this section, and the eligibility criteria established in §155.710(b) or (e), as applicable. In paragraph (l)(2), we propose that the appeal decision must comply with the requirements of §§155.545(a)(2) through (5), which state that a decision must be explained clearly and in plain language, and must summarize the facts relevant to the appeal, identify the legal basis for the decision, and provide the effective date for the decision. These requirements are based on common fair hearing standards, and we intend each piece to assist the employer or employee in understanding how the rules of eligibility and the facts of the case result in the appeal decision. Finally, in paragraph (l)(3), we propose that SHOP appeal decisions be effective retroactive to the date the incorrect eligibility determination was made, if the decision finds the employer or

employee eligible, or effective as of the date of the notice of the appeal decision, if eligibility is denied. We seek comment on these provisions pertaining to the appeal decision.

In paragraph (m), we propose requirements for issuing notice of the SHOP appeals decision. We propose that the appeals entity issue written notice, electronically or in hard copy within 90 days of the receipt of the appeal request to the employer, or to the employer and employee if an employee is appealing, and to the SHOP. The notice must include the contents of the decision described in paragraph (l). Administrative appeal processes within public programs allow a broad range of timeframes (for example, 30-365 days) for submitting appeal requests and adjudicating decisions. We anticipate that 90 days for resolution will be sufficient given the limited criteria involved in SHOP eligibility determinations. We seek comment on these provisions and timeframes.

In paragraph (n), we propose that the SHOP must promptly implement the appeal decision upon receiving notice under paragraph (m) of this section. We did not include a specific timeliness requirement for implementation of the decision in order to provide flexibility for SHOPs, which may vary in their capacity for turnaround times. We seek comment on this provision.

In paragraph (o), we propose that, subject to the requirements in §155.550, the appeal record must be made accessible to the employer, or to the employer and employee if an employee is appealing, in a convenient format and at a convenient time. We anticipate that many employers and employees will be able to access their appeal records electronically through the SHOP. We seek comment on these provisions.

IV. Medicaid Premiums and Cost Sharing

A. Background

Section 1916 of the Act describes long-standing requirements for cost sharing, which apply broadly to all individuals who are not specifically exempted. Such cost sharing is limited

to “nominal" amounts. Section 1916 of the Act also establishes authority for states to impose premiums on specific groups of beneficiaries with family income above 150 percent of the federal poverty level (FPL). The Deficit Reduction Act of 2005 (DRA) established a new section 1916A of the Act, which gives states additional flexibility, allowing for alternative premiums and cost sharing, beyond what is allowed under section 1916 of the Act, for somewhat higher income beneficiaries. Such alternative cost sharing may be targeted to specific groups of beneficiaries and payment may be required as a condition of providing services. Alternative premiums and cost sharing imposed under section 1916A of the Act, cannot exceed five percent of family income.

The current regulations for Medicaid premiums and cost sharing are at 42 CFR 447.50 through 447.82. The first 11 provisions apply primarily to premiums and cost sharing established under the authority of section 1916 of the Act, while the remaining provisions apply primarily to the authority established by section 1916A of the Act. However, some provisions apply to all premiums and cost sharing regardless of the statutory authority, leading to confusion about what is permitted for individuals at various income limits. The proposed regulations make it clear what cost sharing is allowed for individuals with income under 100 percent of the FPL and what flexibilities exist for imposing premiums and cost sharing on individuals with higher income. This proposed rule would eliminate redundant provisions and create consistency between the two statutory authorities where appropriate and consistent with the law. To that effect, we propose to delete in its entirety the current Medicaid premiums and cost sharing rules at §447.50 through §447.82 and to replace them with new §447.50 through §447.57. Sections 447.58 through 447.82 will be reserved.

While this streamlined and simplified approach generally retains current options and limitations consistent with the statute, we are proposing some changes to increase state flexibility. For example, we propose to update the maximum nominal cost sharing amounts,

provide new flexibility to impose higher cost sharing for non-preferred drugs and for non-emergency use of the ED, change the exemption for Indians to ensure that these protections are implemented effectively, and modify the public notice provisions. We seek comment on any element of the proposed rule, which aims to significantly streamline and expand flexibility regarding premiums and cost sharing.

B. Provisions of Proposed Rule

1. Definitions (§447.51)

At §447.51, we propose to add a definition for premiums, which includes enrollment fees and other similar charges. We also propose to add a definition for cost sharing to encompass deductibles, copayments, coinsurance, and other similar charges. Because each of these charges would now be included within cost sharing, we have removed separate requirements related to deductibles, copayments, and coinsurance; all cost sharing would be subject to a single set of parameters as discussed below. We also propose new definitions specific to the premiums and cost sharing rules, for preferred drugs, emergency and non-emergency services, as well as alternative non-emergency service provider, since the cost sharing rules vary for these items and services. We are considering adding definitions of "inpatient stay" and "outpatient services" for purposes of cost sharing to take into account situations where an individual might return to an inpatient institution after a brief period when the return is for treatment of a condition that was present in the initial period. We solicit comments as to the utility of such a definition. Finally we propose a technical correction to the Indian definition to correct the citation to 25 USC 1603.

2. Update to Maximum Nominal Cost Sharing (§447.52)

Under the authority granted under sections 1916(a)(3) and (b)(3) of the Act for the Secretary to define nominal cost sharing, at §447.52(b) we propose to revise the maximum amount of nominal cost sharing for outpatient services, which may be imposed on beneficiaries with incomes below 100 percent of the FPL. Currently, maximum allowable cost sharing is tied

to what the agency pays for the service. This can be confusing and burdensome for states, providers, and beneficiaries. For example, for fiscal year 2013, states may charge up to $1.30 for outpatient services, if the agency pays $10.01 to $25, and up to $3.90 if the agency pays more than $50.

To simplify the rules, we propose to remove the state payment as the basis for the cost sharing charge and replace it with a flat $4 maximum allowable charge for outpatient services. The $4 maximum for outpatient services is comparable to the amount, states may charge under current rules ($3.90) for services for which the state pays more than $50. Because the majority of state services are reimbursed at more than $50, we believe a flat $4 cost sharing maximum is reasonable. We seek comment on this amount as well as the proposed approach in general, including the impact on individuals with significant service needs, such as those with disabilities who are residing in the community.

At §447.52(b)(3), we propose that the maximum cost sharing established by the agency should not be equal to or exceed the amount the agency pays for the service. In accordance with the statute, we also propose that these proposed nominal amounts continue to be updated; however, since we are proposing to increase the nominal amounts, effective in fiscal year 2014, we propose to freeze the next CPI-U increase until October 2015. This increase is also applied to the nominal amounts for drugs and non-emergency use of the emergency depart in §447.53 and §447.54, respectively.

Current rules permit cost sharing for institutional care, up to 50 percent of the cost for the first day of care, for individuals with incomes below 100 percent of the FPL. We are not proposing a change but are considering alternatives for the maximum allowable cost sharing related to an inpatient stay because this is a relatively high cost for very low income people and not a service that consumers have the ability to avoid or prevent. Options under consideration include the $4 maximum applied to outpatient services, $50, or $100, which would encompass

the majority of hospital cost sharing currently in effect. If we were to revise the maximum allowable cost sharing for an inpatient stay, we are considering a transition period, for example, through October 1, 2015, to permit states time to make adjustments to their cost sharing and payment rate schedules. We seek comment on the best approach to cost sharing for an inpatient stay for very low-income individuals.

Beyond the differentiation between inpatient and outpatient care for purposes of establishing nominal levels of permissible cost sharing, we are also considering a separate distinction for nominal levels of cost sharing for community-based long-term services and supports. Community-based long-term services and supports may include services such as personal care, home health, and rehabilitative services that are furnished over an extended period of time pursuant to a coordinated plan of care. The delivery of these services differs from other outpatient services that are furnished in finite increments. As a result, we are considering whether it may be more appropriate to define nominal cost sharing differently for community-based long-term services and supports, or perhaps to refine the treatment of nominal cost sharing generally for a continuous coordinated course of care. We seek comment on these approaches, including how we would define long-term services and supports and the unit of service for which separate cost sharing could be charged. As states exercise their options with respect to cost sharing, they should continue to be aware of their independent obligations under the Americans with Disabilities Act and the Supreme Court's Olmstead decision.

3. Higher Cost Sharing Permitted for Individuals with Incomes above 100 percent of the FPL (§447.52)

Proposed §447.52 consolidates the requirements for cost sharing established under sections 1916 and 1916A of the Act. Under the statute, states may impose cost sharing at higher than nominal levels for nonexempt individuals with incomes at or above 100 percent of the FPL. Section 1916A provides that states may establish cost sharing for nonexempt services, other

than drugs and ED services, up to 10 percent of the cost paid by the state for such services, for individuals with incomes between 100 and 150 percent of the FPL. This option is described in the newly proposed §447.52; cost sharing for drugs and emergency department services are separately addressed. At §447.52(c), we clarify that states may target cost sharing for individuals with family income above 100 percent of the FPL, meaning they may have differential cost sharing levels for different groups of individuals. We seek comment on whether the regulations should specifically address the types of targeting that would be allowed, keeping in mind that such targeting must be based on reasonable categories of beneficiaries, such as a specific income group or population. In addition, we seek comment on state methodologies or administrative processes that would make such targeting easier to implement.

4. Cost sharing for drugs (§447.53)

At §447.53, we propose to establish a single provision specific to cost sharing for drugs so that the policies related to drugs can be clearly referenced. Building on current policy allowed by statute, proposed §447.53 would specifically authorize states to establish differential cost sharing for preferred and non-preferred drugs, limited to the maximum amounts proposed at §447.53(b). This cost sharing flexibility applies to individuals at all income levels.

Section 1916A(c) of the Act limits cost sharing for preferred drugs to nominal amounts (at all income levels). Section 1916A(c) also limits cost sharing for non-preferred drugs to nominal amounts, for individuals with family income at or below 150 percent of the FPL and individuals who are otherwise exempt from cost sharing. To provide additional flexibility to states, and to further encourage the use of preferred drugs, we are proposing to define nominal for this purpose so as to allow cost sharing of up to $8 for non-preferred drugs for individuals with income equal to or less than 150 percent of the FPL or who are otherwise exempt from cost sharing. States will have the flexibility to apply differential cost sharing for preferred and non-preferred drugs in whatever manner they consider most effective. For example, a state may

charge $2 for preferred and $6 for non-preferred drugs or $0 for preferred and $8 for non-preferred drugs.

For individuals with family income above 150 percent of the FPL, per section 1916A(c) of the Act, cost sharing for non-preferred drugs may not exceed 20 percent of the cost the agency pays for the drug.

At §447.53(a), we clarify our existing policy that all drugs will be considered preferred drugs if so identified or if the agency does not differentiate between preferred and non-preferred drugs.

5. Cost sharing for emergency department services (§447.54)

At §447.54, we propose a new regulatory provision specific to non-emergency services furnished in a hospital emergency department (ED). Sections 1916(a)(3) and 1916(b)(3) of the Act allow states to establish cost sharing for non-emergency use of the ED of up to twice the nominal amount for outpatient services with a waiver. In addition, section 1916A(e)(2)(A) of the Act allows states to establish targeted cost sharing for individuals with family income above 100 and at or below 150 percent of the FPL in an amount not to exceed twice the nominal amount for such services. In order to make it easier for states to utilize existing flexibilities to reduce non-emergency use of the ED, at §447.54(a) we propose to allow cost sharing of up to $8 for non-emergency use of the ED no waiver will be required. We seek comment on this approach, which can complement a range of other strategies available to states to reduce nonemergency use of the ED. For individuals with family income above 150 percent of the FPL, per section 1916A(e) of the Act, there is no limit on the cost sharing that may be imposed for non-emergency use of the ED.

If an emergency condition does not exist, §447.54(d) includes the requirements for hospital screening and referral currently codified at §447.80(b)(2), to ensure that beneficiaries have appropriate access to other sources of care, before cost sharing is imposed. Hospitals must

assess the individual clinically, identify an accessible and available alternative provider with lesser cost sharing, and establish a referral to coordinate scheduling. Examples of accessible alternative providers are those that are located within close proximity, accessible via public transportation, open extended hours, and able to serve individuals with LEP and disabilities. (Note that for exempt populations, there must be access to an alternative provider with no cost sharing). For any individual who presents with an emergency medical condition, the hospital must provide stabilizing treatment per the Emergency Medical Treatment and Active Labor Act (EMTALA), as codified at §489.24. An emergency medical condition is currently defined at §438.114 as having "acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention" to seriously jeopardize or impair the individual's health. The EMTALA screening requirements combined with the prudent layperson standard for an emergency medical condition make it difficult to determine a service as non-emergency just based on CPT code. Chest pains, for example, could easily be considered an emergency condition under the prudent layperson standard, though a medical screening may indicate that the individual is suffering from heartburn or anxiety, which may not otherwise be considered emergency medical conditions. While the applicable CPT code might indicate a non-emergency condition, such chest pains would meet the definition of emergency medical condition and therefore may not be assessed a copayment. States have flexibility to consider how best to address some of these logistical and clinical challenges that exist when applying cost sharing to non-emergency use of the ED. To better understand the approaches used by states, at proposed 447.52(f)(5), we would request that states describe the process by which non-emergency services are identified, when submitting a state plan amendment to implement such cost sharing. As successful approaches are identified, CMS will make that information available to states.

We seek comment on these standards and procedures, on ways to make this provision a viable option for states and hospitals, and in particular approaches to successfully distinguish between emergency and non-emergency services.

5. Premiums (§447.55)

At proposed §447.55, we consolidate and simplify the requirements for premiums established under sections 1916 and 1916A of the Act. Proposed §447.56(a) describes the option to impose premiums on individuals with family income above 150 percent of the FPL, as established under section 1916A of the Act, while paragraphs (a)(1) through (a)(5) describe the options to impose premiums for specific populations as established under section 1916 of the Act. Except for the minor revisions described below, we are not seeking to change current policy related to premiums.

At §447.56(a)(1), we propose to modify slightly the option under section 1916 of the Act, which allows states to impose premiums on pregnant women described in 1902(l)(1)(A) of the Act. This option currently applies to individuals whose family income equals or exceeds 150 percent of the FPL and we propose to revise the option to apply only to those with family income that exceeds 150 percent of the FPL to align with other allowable premiums. In addition we are removing the reference to infants under age one described in 1902(l)(1)(B) on whom the state may impose premiums under 1916 because they are included in the group of children who may be charged premiums under 1916A of the Act. In so doing, as with pregnant women, premiums would be allowed for infants with family income exceeding 150 percent of the FPL rather than those with income equal to or exceeding 150 percent of the FPL. In addition, with this change, consistent with current state practice, all premiums imposed on infants will be subject to the aggregate limit of 5 percent of family income. We recognize that the statutory citations for the pregnant women who can be charged premiums do not line up with the streamlining and collapsing of eligibility groups in Medicaid eligibility final rule. We are exploring the options

we have to cite to the new regulation rather than the statute.

To provide clarity and ensure a comprehensive policy, at §447.55 paragraphs (a)(2) through (4) we add language from section 1916 describing the basis for charging premiums to working disabled individuals described at sections 1905(p)(3)(A)(i) and 1902(a)(10)(A)(ii)(XVI) of the Act and disabled children provided medical assistance under section 1902(a)(10)(A)(ii)(XIX) of the Act in accordance with the Family Opportunity Act.

At §447.55(a)(5), we propose to revise requirements related to premiums imposed on medically needy individuals whose income is under 150 percent of the FPL. We removed the current income-related scale currently at §447.52(b) and instead would provide states with the flexibility to determine their own sliding scale for establishing premiums for the medically needy up to maximum of $20 instead of the $19 in current regulation. We also propose to remove the requirement that premiums must be based on gross income, since starting in 2014, all income for purposes of determining premiums will be based on modified adjusted gross income (MAGI).

6. Limitations on Premiums and Cost sharing (§447.56)

At §447.56, we propose one single section that describes the general premium and cost sharing limitations. The current regulations have duplicative provisions specific to sections 1916 and 1916A of the Act and we propose a single streamlined approach wherever the policies align. We do not believe that the proposed change would have a meaningful impact on current state programs.

Sections 1916(a), (b), and (j), and 1916A(b)(3) of the Act specify certain groups of individuals exempt from premiums and/or cost sharing, including certain children, pregnant women, American Indians and Alaska Natives (Indians), individuals residing in an institution, individuals receiving hospice care and women eligible through the Breast and Cervical Cancer Treatment and Prevention Program. Proposed 447.56(a) would align all of these statutory exemptions.

At §447.56(a)(1)(v), we propose to revise the current exemption at §447.53(b)(3) and §447.70(a)(5) for individuals in an institution who are required to spend all but a minimal amount of their income for personal needs, to allow a state option to include individuals under this exemption who are receiving services in a home and community-based setting. Since these individuals are only allowed to keep a personal needs allowance, similar to those residing in an institution, we propose to allow states to exempt these individuals from cost sharing in the same manner as those residing in an institution in accordance with the comparability requirements under section 1902(a)(19) of the Act.

At§447.56(a)(1)(vii), we propose to clarify the exemption of Indians currently at §447.53(b)(6) and §447.70(a)(10) from cost sharing to ensure that Indians are not charged cost sharing inappropriately. Section 1916(j) of the Act requires that no cost sharing "shall be imposed against an Indian who is furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services." Section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603), as amended by the Affordable Care Act, further clarified these requirements by defining contract health services as any health service that is "delivered based on a referral by, or at the expense of, an Indian Health Program." Because no formal paper trail may occur for the Medicaid agency to establish that a service has been delivered based on a referral under contract health services, we propose a broad definition of the cost sharing exemption for Indians. We propose that those Indians who are currently receiving or have ever received an item or service furnished by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) or through referral under contract health services are exempt from all cost sharing. With this clarification the Medicaid agency would not have to know if a particular service was provided based on contract health service referral and would ensure that Indians who should be exempt on such bases will not be inadvertently charged cost sharing. States could

implement this exemption by using claims payment data to identify Indians who have accessed services from an I/T/U, or as many states have done, by requesting that eligible Indians submit a letter, available through the Indian Health Service, designating them as Indians who have utilized such services and are, therefore, exempt from Medicaid cost sharing. We note that this provision would not impact contract health services eligibility or payment regulations. Authorization for payment by a contract health service program remains subject to all requirements of 42 CFR part 136.

We are considering requiring that states apply a periodic renewal process for exempting Indians from cost sharing, such that the exemption would not be indefinite, but would instead be limited to a certain period of time following utilization of services at an I/T/U or under a contract health services referral. This would be consistent with a reading that the exemption applies for Indians who are currently receiving services through an I/T/U or contract health services referral, to eliminate any burden the absence of cost sharing would impose on those providers, who are not permitted to collect any payment from an eligible Indian. We seek comment on the feasibility of initiating a periodic renewal process for the Indian exemption, as well as an appropriate time frame for such renewals.

At §447.56(a)(1)(viii), we propose to extend the existing exemption for individuals needing treatment for breast or cervical cancer, currently applied only to alternative cost sharing under section 1916A of the Act, to all cost sharing, and to cite to §435.213, as added in this proposed rule. With this modification, this exemption is extended to apply to men as well since they are encompassed under §435.213.

Consistent with §435.116(d), which describes covered services for pregnant women as laid out in the Medicaid eligibility final rule (77 FR 17204), at §447.56(a)(2)(iv) we propose to revise the exemption for pregnancy-related services so that all services provided to pregnant women shall be considered pregnancy-related unless specifically identified in the state plan as

not pregnancy-related. We are also codifying the requirement in the Affordable Care Act to exempt smoking cessation counseling and drugs for pregnant women from cost sharing.

We recognize that the statutory citations for children who are exempt from premiums and cost sharing do not line up with the streamlining and collapsing of eligibility groups in Medicaid eligibility final rule. We are exploring the options we have to cite to the new regulation rather than the statute.

At §447.56(b), we propose to codify the existing statutory requirement to ensure comparability, such that states may not exempt additional populations from cost sharing, except in the case of targeted cost sharing. Any cost sharing included in the state plan would be applied equally to services provided under fee-for-service, managed care, or benchmark coverage. At proposed §447.56(c)(2), we move existing regulations at §447.57 and §447.82 requiring the agency to reduce the payment it makes to providers by the amount of a beneficiary's cost sharing obligation.

At §447.56(f) we update the requirements around aggregate limits for premiums and cost sharing to be based on the Medicaid household as defined in §435.603(f) of the Medicaid eligibility final rule and revised in this proposed rule. Existing regulations at §§447.64(d)(2) and 447.68(d) provide that an agency cannot rely solely on families who are risk of reaching the aggregate limit to track their own premiums and cost sharing, we clarify that this means that the agency must have an automated system in place to do such tracking. At §447.56(f)(6), we indicate that the agency may establish additional aggregate limits, including but not limited to a monthly limit on cost sharing charges for a particular service. This new paragraph replaces the paragraph related to cumulative maximums at §447.54(d) of the current regulations. We seek comment on whether there are efficient alternatives to using an automated system to conduct this tracking.

7. Beneficiary and Public Notice Requirements (§447.57)

At §447.57 we have included the existing requirements for notice regarding current premiums and cost sharing and changes to such premiums and cost sharing, as currently described at §447.76. At proposed 447.57(b) we codify existing policy that requires that notice be provided in a manner ensuring that affected beneficiaries, providers, and the general public have access to the notice. Appropriate formats for providing notice might include, the agency website, newspapers with wide circulation, web and print media reaching racial, ethnic, and linguistic minorities, stakeholder meetings, and formal notice and comment in accordance with the state's administrative procedures. With this proposed revision, we would no longer consider state legislation discussed at a public hearing or posted on a website to be sufficient notice that a beneficiary or provider would likely have been made aware of the premium or cost sharing changes. At proposed §447.57(c) we clarify that prior to submitting to CMS any state plan amendment that establishes or significantly modifies existing premiums or cost sharing , orchanges the consequences for non-payment of cost sharing, the agency must provide the public with advance notice of the amendment and opportunity to comment. We are considering a policy that if cost sharing is substantially modified during the SPA approval process, the agency must provide additional public notice and seek comment on this approach.

V. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

This proposed rule continues to implement key provisions of the Affordable Care Act including the appeals process for the Medicaid and Children's Health Insurance Program (CHIP) applicants and beneficiaries; requirements for combined eligibility notices; and completion of the streamlining of eligibility for children, pregnant women, and adults that was initiated in the Medicaid eligibility final rule published on March 23, 2012. This rule also proposes to streamline the citizenship documentation requirement rules consistent with the statute and proposes a revision regarding Medicaid eligibility determinations made by Exchanges. The rule proposes to implement provisions of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), such as those related to deemed newborn eligibility, and modifies CHIP rules relating to substitution of coverage and premium lock-out periods, which are important to a coordinated system of coverage across programs.

The policies proposed in this rule will result in a reduction in burden for individuals applying for and renewing coverage, as well as for states. The Medicaid program and CHIP will be made easier for states to administer and for individuals to navigate by streamlining Medicaid eligibility and simplifying Medicaid and CHIP eligibility rules for most individuals, Even though there are short-term burdens associated with the implementation of the proposed rule, the Medicaid program and CHIP will be easier for states to administer over time due to the streamlined eligibility and coordinated efforts for Medicaid, CHIP, and the new affordable insurance exchanges.

The proposed rule also continues to implement provisions related to the establishment of Exchanges. This proposed rule would: (1) set forth standards for adjudicating appeals of individual eligibility determinations and exemptions from the individual responsibility requirements, as well as determinations of employer-sponsored coverage, and determinations of SHOP employer and employee eligibility for purposes of implementing section 1411(f) of the Affordable Care Act, (2) set forth standards for adjudicating appeals of employer and employee eligibility to participate in the SHOP, (3) outline criteria related to the verification of enrollment in and eligibility for minimum essential coverage through an eligible employer-sponsored plan, and (4) further specify or amend standards related to other eligibility and enrollment provisions. The description of the burden estimates associated with these provisions is included in the information collection requirements outlined in section D.

Section A outlines the information collection requirements in this proposed regulation that will be addressed through a separate notice and comment process under the Paperwork Reduction Act (PRA). Section B outlines the information collection requirements that involve Medicaid and CHIP eligibility and enrollment. We are soliciting public comment on each of these issues for the following sections of the proposed rule that contain information collection requirements (ICRs). We used data from the Bureau of Labor Statistics to derive average costs

for all estimates of salary in establishing the information collection requirements. Salary estimates include the cost of fringe benefits, calculated at 35 percent of salary, which is based on the June 2012 Employer Costs for Employee Compensation report by the U.S. Bureau of Labor Statistics.

A. Medicaid and CHIP Information Collection Requirements (ICRs) to be Addressed through Separate Notices and Comment Process Under the Paperwork Reduction Act

1. ICRs Regarding State Plan Amendments

1a. (§§ 430.12, 431.10, 431.11, 433.138, 433.145, 433.147, 433.148, 435.110, 435.112, 435.115, 435.116, 435.117, 435.139, 435.145, 435.150, 435.170, 435.172, 435.201, 435.210, 435.211, 435.213, 435.214, 435.215, 435.220, 435.222, 435.226, 435.227, 435.229, 435.301, 435.310, 435.406, 435.407, 435.601, 435.602, 435.603, 435.610, 435.831, 435.905, 435.910, 435.917, 435.918, 435.926, 435.952, 435.955, 435.956, 435.1100 – 1110, 435.1200, 440.130, 440.210, 440.220, 440.305, 440.315, 440.330, 440.335, 440.345, 457.50, 447.52, 447.55, 447.56, 457.320, 457.342, 457.348, 457.355, 457.360, 457.455, 457.460, 457.465, 457.805, 457.495, and 457.1120).

These amendments to the Medicaid and CHIP state plans are necessary to reflect changes in statute and federal policy. We are aware of the need to estimate the PRA burden associated with the submission of state plan amendments related to the provisions described in the preceding sections of the preamble. The state plan amendments will be addressed as part of the electronic state plan being developed by CMS as part of the MACPro system. The MACPro system will be made available for public comment through a separate PRA process, along with the estimated burden.

1b. (§§435.113, 435.114, 435.223, and 435.510)

We are proposing to eliminate the following provisions of existing regulation: §§435.113, 435.114, 435.223, and 435.510. Because we are eliminating these regulations, states

will not be required to submit state plan amendments related to them. Therefore, there is no burden associated with these provisions of the proposed rule.

2. ICRs Regarding Authorized Representatives (§435.923, §457.340), Verification Exception for Special Circumstances (§435.952, §457.320) and Verification Requirements Regarding Citizenship and Immigration Status (§§435.3, 435.4, 435.406, 435.407, 435.940, 435.952, 435.956, 435.1008, 457.320, and 457.380)

In this rulemaking, we propose to add a new §435.923 establishing minimum requirements for the designation of authorized representatives. We are also applying these provisions to state CHIP agencies through the addition of a cross reference in §457.340. At §435.952 and §457.320 we are proposing to permit self-attestation on a case by case basis in special circumstances for individuals who do not have access to documentation (for example, victims of natural disasters). The provisions at §§435.3, 435.4, 435.406, 435.407, 435.940, 435.952, 435.956, 435.1008, 457.320, and 457.380 propose guidelines for verification of Medicaid and CHIP eligibility based on citizenship or immigration status.

We are aware of the need to estimate the PRA burden associated with the collection of information related to authorizing an individual to act as a representative of an applicant, to permit self-attestation for individuals who do not have access to documentation, and the citizenship and immigration verification requirements. These requirements will be addressed as part of the single, streamlined application developed by the Secretary. The application will be made available for public comment through a separate PRA process, along with the estimated burden.

B. ICRs Regarding Medicaid Eligibility and Enrollment

1. ICRs Regarding Delegation of Eligibility Determinations and Appeals (§§431.10, 431.11, and 457.1120)

According to §§431.10, 431.11, and 457.1120 as proposed in this rule, a state may delegate authority to make eligibility determinations and to conduct fair hearings. States generally have written agreements with various entities for similar purposes. Under the proposed rule, agreements may need to be modified or new agreements established. However, states that use the same agency to administer more than one program (for example, Medicaid and the Exchange) will not need an agreement for the determination of eligibility by that agency.

Delegation of eligibility determinations was approved under OMB control number 0938-1147. This rule is proposing minor changes in the existing requirement related to the type of agencies that can make Medicaid and CHIP eligibility determinations. These proposed amendments do not change the burden associated with the requirement and, therefore, are not subject to additional OMB review. Medicaid and CHIP agencies will need to establish new agreements in order to delegate authority to conduct eligibility appeals. The burden associated with the delegation of appeals is the time and effort necessary for the Medicaid and CHIP agencies to create and execute the agreements with the organization to which they are delegating authority.

There are 53 Medicaid agencies (the 50 states, the District of Columbia, Northern Mariana Islands, and American Samoa) and 43 CHIP agencies, for a total of 96 agencies. For the purpose of developing the cost burden, we estimate that half of these agencies will establish an agreement with an organization to conduct fair hearings. We estimate a one-time burden of 50 hours to develop an agreement that can be used with the organization. It will take an additional 10 hours for Medicaid and 10 hours for a separate CHIP agency to negotiate and execute the agreement with the organization for a total time burden of 2,880 hours across all agreements. For the purpose of the cost burden, we estimate it will take a health policy analyst 40 hours at $49.35 an hour and a senior manager 10 hours at $79.08 an hour to complete the model agreement (for a total of $2,764.80) plus 10 additional hours ($493.50) for a health policy

analyst to execute a completed agreement with each organization. The estimated cost burden for each agreement is $3,258.30 for a total cost burden of $156,398.40.

2. ICRs Regarding Fair Hearing Processes (§§431.205(e), 431.206(b)(4) and (c)(5), 431.210, 431.221(a), 431.224(a), 431.232(b), and 431.240(c))

In §§431.205(e) and 431.206(c)(5), we propose to require that the hearing system and information must be accessible to persons who are limited English proficient and persons with disabilities. While states would be required to make the hearing system accessible, we believe the associated burden is exempt from the PRA in accordance with 5 CFR 1320.3(b)(2). We believe that the time, effort, and financial resources necessary to comply with this requirement would be incurred by persons during the normal course of their activities and should, therefore, be considered as a usual and customary business practice.

In §431.206(b)(4), states would be required to give individuals the choice of where to have their hearing held. There are 53 Medicaid agencies (the 50 states, the District of Columbia, Northern Mariana Islands, and American Samoa) and 43 CHIP agencies for a total of 96 agencies that will be subject to this requirement. The burden associated with providing this choice is developing the process and workflow to enable the choice and sending the request for the fair hearing to the appropriate agency. We estimate it will take each agency an average of 70 hours to create the process and workflow required in providing the choice. For the purpose of the cost burden, we estimate it will take a health policy analyst 40 hours at $49.35 an hour, a senior manager 10 hours at $79.08 an hour, and a computer programmer 20 hours at $52.50 to complete the process and workflow. The estimated cost burden for each agency is $3814.80. The total estimated cost burden is $366,220.80.

In §§431.210 and 431.232(b), we are clarifying the type of information that must be included in the fair hearing notices. While states will need to provide additional explanation of the reason for their action and the right and timeframe for appealing the decision, we believe the

associated burden is exempt from the PRA in accordance with 5 CFR 1320.3(b)(2). We believe that the time, effort, and financial resources necessary to comply with this requirement would be incurred by persons during the normal course of their activities and should, therefore, be considered as a usual and customary business practice.

In §431.221(a), states would be required to establish procedures that permit an individual or an authorized representative to submit a hearing request by telephone, by mail, in person, or by the internet. While states would be required to permit an individual to submit the request through these various means, we believe the associated burden is exempt from the PRA in accordance with 5 CFR 1320.3(b)(2). We believe that the time, effort, and financial resources necessary to comply with this requirement would be incurred by persons during the normal course of their activities and should, therefore, be considered as a usual and customary business practice.

In §431.224(a), states would be required to establish and maintain an expedited review process for hearings for individuals for whom taking the time for a standard hearing could seriously jeopardize the individual's life or health. While states would be required to have an expedited review process for hearings, we believe the associated burden is exempt from the PRA in accordance with 5 CFR 1320.3(b)(2). We believe that the time, effort, and financial resources necessary to comply with this requirement would be incurred by persons during the normal course of their activities and should, therefore, be considered as a usual and customary business practice.

In §431.240(c), states would be required to ensure that a hearing office has access to the information necessary to issue a proper hearing decision, including access to the agency's policies and regulation. While the agency would be required to make this information available, we believe the associated burden is exempt from the PRA in accordance with 5 CFR 1320.3(b)(2). We believe that the time, effort, and financial resources necessary to comply with

this requirement would be incurred by persons during the normal course of their activities and should, therefore, be considered as a usual and customary business practice.

3. ICRs Regarding Eligibility Determination Notices (§§435.917, 435.918, 435.1200, 457.110, 457.340, 457.348, and 457.350)

In §435.917 and §457.340, the agency would be required to provide a timely combined notice to individuals regarding their eligibility determination. The notice is to include reasons for the action, the specific supporting action, and an explanation of hearing rights. We expect that the eligibility determination notice will be dynamic and include information tailored to all possible outcomes of an application or renewal. In §435.918 and §457.110, states must provide electronic notices to individuals when elected.

The burden associated with the requirements to deliver notices is the time necessary for the state staff to understand the requirements related to notices; to develop the language for approval, denial, termination, suspension, and change of benefits notices; and to program the language in the Medicaid and CHIP notice systems so that the notice can be populated and generated based on the outcome of the eligibility determination.

We estimate 53 state Medicaid agencies (the 50 states, the District of Columbia, Northern Mariana Islands, and American Samoa) and 43 CHIP agencies (in states that have a separate or combination CHIP), totaling 96 agencies, will be subject to this requirement. We estimate that it will take each Medicaid and CHIP agency 194 hours annually to develop, automate, and distribute the notice of eligibility determination. For the purpose of the cost burden, we estimate it will take a health policy analyst 138 hours at $49.35 an hour, a senior manager 4 hours at $79.08, an attorney 20 hours at $90.14, and a computer programmer 32 hours at $52.50 to complete the notices. The estimated cost burden for each agency is $10,609.42. The total estimated cost burden is $1,018,504.30, and the total annual hour burden is 18,624 hours.

In §§435.1200, 457.348, and 457.350, we propose to permit state Medicaid and CHIP agencies to include the provision of combined notices or notices with coordinated content in the agreement established with the Exchange or other insurance affordability programs. These agreements were approved under OMB control number 098-1147. This rule is proposing only minor changes in the existing requirement related to the agreements. These proposed amendments do not change the burden associated with the requirement and, therefore, are not subject to additional OMB review.

4. ICRs Regarding Application Assistors (§§435.909 and 457.340)

In §435.909(a) and §457.340, states would have the option to authorize certain staff and volunteers of organizations to act as certified application assistors. The burden associated with the requirements to assist individuals with the application process is the time and effort necessary for the state to create agreements with these organizations, to create a registration process for assistors, and to train staff on the eligibility and confidentiality rules and requirements and how to assist applicants with the completing the application.

We estimate the 50 states, the District of Columbia, Northern Mariana Islands, and American Samoa will establish agreements with on average 20 organizations in their state or territory for a total of 1060 agreements related to application assistance. As part of this estimate, we assumed that state Medicaid and CHIP agencies will be party to the same agreements and, therefore, will not establish separate agreements. The first burden associated with this provision is the time and effort necessary for the state Medicaid and CHIP agencies to establish an agreement.

We assume that each state will establish an agreement with the organization to fulfill the requirements of §435.908 and §457.340. To develop an agreement, we estimate 53 states Medicaid agencies (the 50 states, the District of Columbia, Northern Mariana Islands, and American Samoa) would be subject to this requirement. We estimate that it would take each

state and territory 50 hours to develop a model agreement. For the purpose of the cost burden, we estimate it would take a health policy analyst 40 hours at $49.35 an hour and a senior manager 10 hours at $79.08 to develop an agreement. The estimated cost burden would be $2,764.80 (per state) or $146,534.40 (total) while the total annual hour burden would be 2,650 hours.

To negotiate and complete the agreement, we estimate that each of the 53 states/territories would execute 20 agreements. For the purpose of the cost burden, we estimate it would take a health policy analyst 10 hours at $49.35 an hour to execute each agreement. The estimated cost burden would be $9,870 (per state) or $523,110 (total) while the total annual hour burden would be 10,600 hours.

To develop and execute the model agreements, the total cost would be $669,644.40 for 13,250 hours of labor.

The next burden associated with this provision is the time and effort necessary for the states and territories to establish the registration process and workflow for the application assistors. We estimate that the 50 states, the District of Columbia, Northern Mariana Islands, and American Samoa) will be subject to this requirement.

We estimate it will take each state or territory an average of 70 hours to create the registration process and workflow for the application assistors. For the purpose of the cost burden, we estimate it will take a health policy analyst 40 hours, at $49.35 an hour, a senior manager 10 hours, at $79.08 an hour, and a computer programmer 20 hours at $52.50 to complete the registration process and workflow. The estimated cost burden for each state or territory is $3814.80. The total estimated cost burden is $202,184.40.

The next burden associated with this provision is the time and effort necessary for the state Medicaid and CHIP agencies to provide training to the application assistors. We estimate

50 states, the District of Columbia, Northern Mariana Islands, and American Samoa will be subject to this requirement.

For the purpose of the cost burden, we estimate it will take a training specialist 40 hours at $26.64 an hour and a training and development manager 10 hours at $64.43 an hour to develop training materials for the application assistors, for a total time burden of 2,650 hours. The estimated cost burden for each state or territory is $1,709.90. The total estimated cost burden is $90,624.70.

Lastly, we estimate that each state or territory will offer 50 hours of training sessions to train individuals to assist applicants with Medicaid and CHIP applications for a total time burden of 2650 hours. For the purpose of the cost burden, we estimate it will take a training specialist 50 hours at $26.64 an hour to train the application assistors. The estimated cost burden for each agency is $1,332. The total estimated cost burden is $70,596.

5. ICRs Regarding the Availability of Program Information for Individuals who are Limited English Proficient (§§431.205(e) and 435.905(b))

While states would be required to provide language services to individuals who are limited English proficient, we believe the associated burden is exempt from the PRA in accordance with 5 CFR 1320.3(b)(2). We believe that the time, effort, and financial resources necessary to comply with this requirement would be incurred by persons during the normal course of their activities and should, therefore, be considered as a usual and customary business practice.

6. ICRs Regarding Presumptive Eligibility (§§435.1101(b) and 457.355)

In §435.1101(b) and §457.355 by reference to §435.1101, states would be required to provide qualified entities with training in all applicable policies and procedures related to presumptive eligibility. The burden associated with this provision is the time and effort necessary for the states and territories to provide training to the application assistors. We

estimate 50 states, the District of Columbia, Northern Mariana Islands, and American Samoa will be subject to this requirement. As part of this estimate, we assumed that state Medicaid agencies and CHIP agencies, where there are separate agencies, will develop and use the same training.

For the purpose of the cost burden, we estimate it will take a training specialist 40 hours at $26.64 an hour and a training and development manager 10 hours at $64.43 an hour to develop training materials for the qualified entities, for a total time burden of 2,650 hours. The estimated cost burden for each state or territory is $1,709.90. The total estimated cost burden is $90,624.70. We estimate that each state or territory will offer 50 hours of training sessions to qualified entities, for a total time burden of 2,650 hours. For the purpose of the cost burden, we estimate it will take a training specialist 50 hours at $26.64 an hour to train the application assistors. The estimated cost burden for each agency is $1,332. The total estimated cost burden is $70,596.

7. ICRs Regarding Deemed Newborn Children (§§435.117(d) and 457.360(d))

In §435.117(d) and §457.360(d), states would be required issue separate Medicaid identification numbers to babies covered by Medicaid as "deemed newborns" if the mother for the date of the child's birth was receiving Medicaid in another state, covered in the state's separate CHIP, or covered for only emergency medical services. Also, the state must issue a separate Medicaid identification number to a deemed newborn prior to the effective date of any termination of the mother's eligibility or prior to the date of the child's first birthday, whichever is sooner. Under such circumstances, a separate Medicaid identification number must be assigned to the infant so the state may reimburse providers for covered services, document the state's expenditures, and request federal financial participation.

While states are required to issue Medicaid identification numbers to these children, we believe the associated burden is exempt from the PRA in accordance with 5 CFR 1320.3(b)(2).

We believe that the time, effort, and financial resources necessary to comply with this requirement would be incurred by persons during the normal course of their activities and should, therefore, be considered as a usual and customary business practice.

8. ICRs Regarding Adoption Assistance Agreements (§§435.145 and 435.227)

At §§435.145 and 435.227, we are proposing to amend current regulations for these Medicaid eligibility groups for consistency with federal statutory requirements. Among the eligibility requirements and alternatives for these groups is that an adoption assistance agreement be in effect. As noted in section A, Medicaid state plan amendments for these and other eligibility groups will be addressed through a separate notice and comment process under PRA. This proposed rule is not making any revision to states' adoption assistance agreements. These agreements are between state agencies and the adoptive parents and are specific to the rules and laws in place in each state. We do not govern these agreements; therefore, there is no burden associated with these provisions of the proposed rule.

9. ICRs Regarding Enrollment Assistance and Information Requirements (§457.110)

While states would be required to provide accurate and easily understood information and to provide assistance to help families make informed decisions about their health plans, professionals, and facilities, we believe the associated burden is exempt from the PRA in accordance with 5 CFR 1320.3(b)(2). We believe that the time, effort, and financial resources necessary to comply with this requirement would be incurred by persons during the normal course of their activities and should, therefore, be considered as a usual and customary business practice.

10. ICRs Regarding Medicaid and CHIP Agency Responsibilities Related to Coordination Involving an Appeals Entity (§§435.1200(g) and 457.348(d))

In §435.1200(g) and §457.348(d), the state Medicaid and CHIP agencies would be required to establish a secure electronic interface to enable communications when an appeal is

filed. Transmission of the electronic account would contain the outcome of the appeal among the data elements. The requirement for a secure electronic interface, creation of an electronic account and transmission of information in the account was addressed under OMB control number 0938-1147. We are only minimally changing this requirement to include information on eligibility appeals. The inclusion of this information does not change the burden estimate therefore this provision is not subject to further OMB review.

11. ICRs Regarding Beneficiary and Public Notice Requirements (§447.57)

In §447.57(a), the agency would be required to make available a public schedule describing current premiums and cost sharing requirements containing the information in paragraphs (a)(1) through (6). In §447.57(b), the agency would be required to make the public schedule available to those identified in paragraphs (b)(1) through (4).

Prior to submitting a SPA for Secretary approval to establish or modify existing premiums or cost sharing or change the consequences for non-payment, §447.57(c), would require that the state provide the public with advance notice of the SPA (specifying the amount of premiums or cost sharing and who is subject to the charges); provide a reasonable opportunity to comment on SPAs that propose to substantially modify premiums and cost sharing; submit documentation to demonstrate that these requirements were met; and provide additional public notice if cost sharing is modified during the SPA approval process.

In §447.57(d), the information must be provided in a manner that ensures that affected beneficiaries and providers are likely to have access to the notice and be able to provide comments on proposed state plan amendments.

The burden associated with this requirement is the time and effort it would take for a state to provide advance notice to the public and prepare and submit documentation with the state plan amendment. We estimate it would take 1 state or territory approximately 6 hours to meet this requirement; we believe 53 states will be affected by this requirement for an annual

burden of 30 hours.

C. Part 155 --Exchange Establishment Standards and Other Related Standards Under the Affordable Care Act

It is important to note that these regulations involve several information collections that will occur through the single, streamlined application for enrollment in a QHP and for insurance affordability programs described in 45 CFR 155.405. We have accounted for the burden associated with these collections in the Supporting Statement for Data Collection to Support Eligibility Determinations for Insurance Affordability Programs and Enrollment through Health Benefits Exchanges, Medicaid, and Children's Health Insurance Program Agencies (CMS-10440).

We would also like to highlight that this supporting statement includes several information collections from regulatory provisions finalized in the Exchange final rule. We have included these information collections in this PRA package to address PRA requirements related to those provisions as they were not included in the information collection section of the Exchange final rule.

1. ICRs Regarding Appeals (§§155.505, 155.510, 155.520, 155.530, 155.535, 155.540, 155.545, 155.550, 155.555, 155.740)

The eligibility appeals provisions in subparts F and H include requirements for the collection of information that will support processing and adjudicating appeals for individuals, employers facing potential tax liability, and SHOP employers and employees. The information collection will be largely the same for each type of appeal and includes the appeal request, expedited appeal request, appeal withdrawal, request to vacate, request for additional information, hearing request form, special considerations form, and appointment of authorized representative. We anticipate most appellants will opt to accept and respond to these forms and notices electronically; however, appeals entities will be equipped to handle the sending and

submission of paper forms and documents. Appellants providing information to the appeals entity will likely need to search their personal files at home or obtain documentation from employers or government entities to support their appeal. If the appellant is an employer, it is likely that the employer may rely on human resources personnel or an attorney to provide information during the appeal. Appeal entities will rely on office clerks and paralegals or legal assistants to process the information submitted. Finally, the use of many of these forms and notices is dependent on the trajectory of each appeal; therefore, not every form will be implicated in each appeal.

The appeal request form will be available to each appellant type in hard copy and electronically but appellants may also request an appeal telephonically. Regardless of the mode of transmission, some basic information will be required to initiate an appeal, including the identity of the appellant and the appellant's contact information. Appellants are encouraged, but not required, to also submit information detailing why they are appealing and evidence to support their appeal. We anticipate that most appellants will choose to submit more than the base-level of information. We estimate that most appellants will complete the form within one hour and that the appeals entity will require up to 1.5 hours to process the form, which includes 0.5 hours for an office clerk, at an hourly cost of $19.97, to digitize and link the form to the appellant's account, and one hour for a paralegal or legal assistant, at an hourly cost of $34.51, to review the information submitted, and notify the appropriate appeals workers of a new appeal request. Across all types of appeals, we estimate a total of 279,055 appeals requests for each year, which will require 418,582 hours, at a total cost of $12,416,553.

Appellants will receive an acknowledgement of his or her appeal request that includes the invitation to submit evidence to support the appeal in the form of the Request for Additional Information Form. Completing this form is optional for all appellants. However, we anticipate that many appellants will use the opportunity to send additional information to the appeals entity.

Much like the appeal request, the appeals entity will be responsible for digitizing the submitted information, placing it in the proper account, and reviewing it. The burden on the appellant is dependent on how easily he or she can access information relevant eligibility. We estimate this may require up to two hours for the appellant. To process additional information submitted, we estimate that the appeals entity will require 0.5 hours for an office clerk, at an hourly cost of $19.97, to digitize and link the form to the appellant's account, and 0.5 hours for a paralegal or legal assistant, at an hourly cost of $34.51, to review the information submitted, and notify the appropriate appeals workers of the updated information, for a total cost of about $27 per appellant.

Other forms the appellant may encounter during the appeals process include the appeal withdrawal form, request to vacate a dismissal, special considerations form, hearing request form, and appointment of authorized representative form. Each of these include information collections that are initiated by the appellant when he or she, for example, wishes to withdraw an appeal or intends to have another person act on his or her behalf. In most cases, the information submitted for these actions will require little more than acknowledging the appellant's intentions and including contact information. The Request to Vacate a Dismissal will entail slightly more effort because, to successfully vacate a dismissal, the appellant must show good cause. We anticipate that these forms may require as little as 15 minutes or up to 2 hours for the appellant to complete and approximately 30 minutes to 1.5 hours for the appeals entity to process for a cost of approximately $10-$45 per submission.

The appeals process also includes several instances where notice of appeals actions must be sent to the Exchange, the SHOP, or Medicaid or CHIP agencies. For example, the appeals entity is required to notify the Exchange or the SHOP when an appeal request has been submitted and when an appeal decision has been issued. This notice will be sent via secure electronic interface. In addition, eligibility records and, in some instances, appeals records must

be transmitted electronically to the appeals entity from the Exchange, the SHOP, or the Medicaid or CHIP agency. To accommodate these electronic notifications and transfers of records, we estimate the Exchange will need to include language in agreements with other agencies administering insurance affordability programs. We estimate that the creation of the necessary agreements will necessitate 35 hours from a health policy analyst at an hourly cost of $49.35, and 35 hours from an operations analyst at an hourly cost of $54.45 to develop the agreement; and 30 hours from an attorney at an hourly cost of $90.14 and five hours from a senior manager at an hourly cost of $79.14 to review the agreement. Accordingly, the total burden on the Exchange associated with the creation of the necessary agreements will be approximately 105 hours and $6,733 per Exchange, for a total cost of $343,382 for 51 Exchanges.

We also propose that appeals entities maintain appeals records and provide the appellant and the public access to those records, subject to applicable state and federal privacy and confidentiality laws. We estimate that an individual requesting access to appeal records may require up to 30 minutes to submit the request form. An employer submitting a similar request may require up to an hour to complete the form at a maximum cost of $62.65, which includes 0.5 hours of time from a human resources specialist at an hourly cost of $40.68 to complete the record request; and 0.25 hours of time from an attorney at an hourly cost of $90.14 and 0.25 hours from a senior manager at an hourly cost of $79.08 to review the request before submission. In order to process record requests, we anticipate the appeals entity will require two hours for a total cost of $42.98 with an additional dollar for the cost of printing and mailing hard copy records. We estimate that the development of the records storage system will necessitate 15 hours from a health policy analyst at an hourly cost of $49.35, and 20 hours from an operations analyst at an hourly cost of $54.45 to provide specifications for the records that need to be maintained; 20 hours from an attorney at an hourly cost of $90.14 and five hours from a senior manager at an hourly cost of $79.14 to provide oversight and supervision; and 120 hours from a

computer programmer at an hourly cost of $52.50 to conduct the necessary system development. Accordingly, the total burden on the Exchange associated with the development of the records storage system will be 159 labor hours with a cost of approximately $9,159 per Exchange and a total cost of $467,131 for 51 Exchanges.

Finally, the appeals process will require the sending of notices to the appellant and other parties throughout the process. Notices include notice of dismissal, notice of hearing, notice of denial of an expedited hearing request, and notice of appeals decision. We expect that the appeal decision notice will be dynamic and include information tailored to the appellant's case. We estimate that the development of each of the necessary notices will necessitate 44 hours from a health policy analyst at an hourly cost of $49.35 to learn appeals rules and draft notice text; 20 hours from an attorney at an hourly cost of $90.14 and four hours from a senior manager at an hourly cost of $79.08 to review the notice; and 32 hours from a computer programmer at an hourly cost of $52.50 to conduct the necessary development. In total, we estimate that the development of each notice specified as part of the appeals process will require 100 hours to complete in the first year, at a cost of $5,971 per Exchange, for a total of $304,497 for 51 Exchanges.

2. ICRs Regarding Notices (§§155.302, 155.310, 155.315, 155.320, 155.330, 155.335, 155.345, 155.410, 155.715, 155.722, 155.725, 155.1080)

Several provisions in subparts D and E outline specific notices that the Exchange will send to individuals and employers throughout the eligibility and enrollment process. The purpose of these notices is to alert the individuals and employers of actions taken by the Exchange. When possible, we anticipate that the Exchange will consolidate this notice when multiple members of a household are applying together and receive an eligibility determination at the same time. The notice may be in paper or electronic format but must be in writing and will be sent after an eligibility determination has been made by the Exchange. We anticipate that a large volume of enrollees will request electronic notification while others will opt to receive the

notice by mail. As a result of certain enrollees opting to receiving the notice by mail in some instances, we estimated the associated mailing costs for the time and effort needed to mail notices in bulk to enrollees as appropriate.

We expect that the electronic eligibility determination notice will be dynamic and include information tailored to all possible outcomes of an application throughout the eligibility determination process. To develop the paper and electronic notices, Exchange staff would need to learn eligibility rules and draft notice text for various decision points, follow up, referrals, and appeals procedures. A peer analyst, manager, and legal counsel would review the notice. The Exchange would then engage in review and editing to incorporate changes from the consultation and user testing including review to ensure compliance with plain writing, translation, and readability standards. The Exchange will also consult with the state Medicaid or CHIP agency in order to develop coordinated notices. Finally, a developer would program the template notice into the eligibility system so that the notice may be populated and generated in the correct format according to an individual's preference to receive notices, via paper or electronically, as the applicant moves through the eligibility process.

HHS is currently developing model eligibility determination notices and several other models for notices described in this subpart which will also decrease the burden on Exchanges to establish such notices. If a state opts to use the model notices provided by HHS, we estimate that the Exchange effort related to the development and implementation of the eligibility notice will necessitate 44 hours from a health policy analyst at an hourly cost of $49.35 to learn appeals rules and draft notice text; 20 hours from an attorney at an hourly cost of $90.14 and four hours from a senior manager at an hourly cost of $79.08 to review the notice; and 32 hours from a computer programmer at an hourly cost of $52.50 to conduct the necessary development. In total, we estimate that this will take a total of 100 hours for each Exchange, at a cost of approximately $5,971 per Exchange and a total cost of $304,497 for 51 Exchanges. We expect

that the burden on the Exchange to maintain this notice will be significantly lower than to develop it.

Section 155.310(h) specifies that the Exchange will notify an enrollee's employer that an employee has been determined eligible for advance payments of the premium tax credits and/or cost-sharing reductions. Upon making such an eligibility determination, the Exchange will send a notice to the employer with information identifying the employee, along with a notification that the employer may be liable for the payment under section 4980H of the Code, and that the employer has a right to appeal this determination. Because this notice will be sent to an employer at the address as provided by an application filer on the application, we anticipate all of these notices will be sent by mail. As a result, we estimated the associated mailing costs for the time and effort needed to mail notices in bulk to employers. Like the eligibility notice, the employer notice above will be developed and programmed into the eligibility system. However, unlike the eligibility notice, we expect the information on the employer notice to be minimal in comparison to the eligibility notice and therefore the burden on the Exchange to develop the notice to be substantially less. Further, as with the individual eligibility notice, HHS will provide model notice text for Exchanges to use in developing this notice.

3. ICRs Regarding Verification of Enrollment in an Eligible Employer-Sponsored Plan and Eligibility for Qualifying Coverage in an Eligible Employer-Sponsored Plan (§155.320)

Section 155.320(d) proposes the process for the verification of enrollment in an eligible employer-sponsored plan and eligibility for qualifying coverage in an eligible employer-sponsored plan. Paragraph (d)(2) specifies that the Exchange will obtain relevant data from any electronic data source available to the Exchange which has been approved by HHS, as well as data from certain specified electronic data sources. This will involve the development and execution of data sharing agreements; however, this burden is already captured in the data sharing agreements described in §155.315. As these verification activities will all be electronic,

we do not expect for there to be any additional burden than that which is required to design the overall eligibility and enrollment system.

Paragraph (d)(3)(iii)(A) proposes that the Exchange provide notice to the applicant indicating that the Exchange will be contacting any employer identified on the application to verify whether the applicant is enrolled in an eligible employer-sponsored plan or is eligible for qualifying coverage in an eligible employer-sponsored plan for the benefit year for which coverage is requested. The burden associated with this notice is addressed in 155.310(g) as this will not be a separate notice, but incorporated into the eligibility determination notice described in the above paragraph.

In paragraph (d)(3)(iii)(D), we propose that the Exchange make reasonable attempts to contact any employer to which the applicant attested employment to verify whether the applicant is enrolled in an eligible employer-sponsored plan or is eligible for qualifying coverage in an eligible employer-sponsored plan for the benefit year for which coverage is requested. It is difficult to estimate the burden associated with this information collection as the calculation involves identifying the number of individuals for whom employer-sponsored coverage information will be unavailable. As such, below, we estimate the time and cost associated with the Exchange making a reasonable attempt to contact one employer. We estimate the time associated with this information collection to be a total of 2.2 hours per employer at a total cost of $34.

Section 155.320(d)(4) proposes that Exchange may satisfy the provisions in this paragraph by relying on a verification process performed by HHS. The burden associated with this provision is the time and effort necessary for the Exchange to establish or modify an agreement for eligibility determinations and coordination of eligibility functions. The burden associated with this provision is included in §155.345.

4. ICRs Regarding Application Counselors and Authorized Representatives (§155.225 and §155.227)

Section 155.225 of the regulation provides the standards on which an Exchange will certify application counselors to facilitate enrollment in the Exchange. Section 155.225(b) outlines the standards for certification of individuals seeking to become application counselors. Section 155.227 of the regulation gives an individual or employee the ability to designate an authorized representative to act on the individual or employee's behalf. Section 155.227(e) outlines the standards for certification if the authorized representative is acting as either a staff member or volunteer of an organization. The burden associated with these provisions is the time and effort necessary for the Exchange to develop and execute agreements with applicable application counselors. For each provision we estimate that it will take 105 hours per Exchange to meet these reporting requirements. This includes a mid-level health policy analyst drafting the agreement with managerial oversight and comprehensive review of the agreement. The estimated cost for each Exchange is $6,733 and a total cost of $343,383 for 51 Exchanges.

5. ICRs Regarding Electronic Transmissions (§§155.310, 155.315, 155.320, 155.330, 155.340, 155.705)

Sections 155.310, 155.315, 155.320, 155.330, 155.340, and 155.705 involve the electronic transmission of data in order to determine eligibility for enrollment in a QHP and for insurance affordability programs. Section 155.310(d)(3) specifies that the Exchange must notify the state Medicaid or CHIP agency and transmit all information from the records of the Exchange to the Medicaid or CHIP agency to ensure that the Medicaid or CHIP agency can provide the applicant with coverage promptly and without undue delay. This applicant information will be transmitted electronically from the Exchange to the agency administering Medicaid or CHIP upon receiving an indication that the Exchange has determined an applicant eligible for such program. The purpose of this data transmission is to notify the agency

administering Medicaid or CHIP that an individual is newly eligible and thus the agency should facilitate enrollment in a plan or delivery system. Data will be transmitted through a secure electronic interface.

Sections 155.315 and 155.320 include transactions necessary to verify applicant information. We expect there to be no transactional burden associated with the electronic transactions needed to implement §155.315 and §155.320. As these transmission functions will all be electronic, we do not expect for there to be any additional burden than that which is required to design the overall eligibility and enrollment system.

In section 155.340, the Exchange must provide the relevant information, such as the dollar amount of the advance payment and the cost-sharing reductions eligibility category, to enable advance payments of the premium tax credit and cost-sharing reductions, reconciliation of the advance payments of the premium tax credit, and employer responsibility. As we hope that these transmissions of information will all be electronic, we do not expect for there to be any additional burden than that which is required to design the overall eligibility and enrollment system.

6. ICRs Regarding Reporting Changes (§§155.315, 155. 330, 155.335)

Section 155.315(f) outlines the process for resolving inconsistencies identified through the verification process. In §155.330(c)(1), we state that the Exchange will verify any information reported by an enrollee in accordance with the processes specified in §§155.315 and 155.320 prior to using such information in an eligibility redetermination. Section 155.335(e) provides that the Exchange will require a qualified individual to report any changes with respect to the information listed in the notice described in paragraph (c) of this section within 30 days from the date of the notice. It is not possible at this time to provide estimates for the number of applicants for whom a reported change will necessitate the adjudication of documentation, but we anticipate that this number will decrease as applicants become more familiar with the

eligibility process and as more data become available. As such, for now, we note that the burden associated with this provision is one hour for an individual to collect and submit documentation, and 12 minutes for eligibility support staff to review the documentation.

7. ICRs Regarding Enrollment and Termination (§§155.400, 155.405, 155.430)

In Part 155, subpart E of the Exchange final rule, we describe the requirements for Exchanges in connection with enrollment and disenrollment of qualified individuals through the Exchange. These information collections are associated with sending eligibility and enrollment information to QHP issuers and to HHS, maintaining records of all enrollments in QHPs through the Exchange, reconciling enrollment information with QHP issuers and HHS, and retaining and tracking coverage termination information. The burden estimates associated with these provisions include the time and cost to meet these record requirements. We estimate that it will take 142 hours for an Exchange to meet these recordkeeping requirements for a total of 7,242 hours.

In the case of the requirement related to termination standards, the burden includes estimates related to the maintenance and transmission of coverage termination information, as well as the time and effort needed to develop the system to collect and store the information. We estimate that it will take approximately 70 hours annually for the time and effort to meet this requirement for a total of 3,570 hours.

8. ICRs Regarding Agreements (§§ 155. 302, 155.225, 155.227, 155.345, 155.510)

These provisions propose that Exchanges and appeals entities will enter into written agreements with agencies administering other insurance affordability programs. These agreements are necessary to minimize burden on individuals, ensure prompt determinations of eligibility and enrollment in the appropriate program without undue delay, prompt issuance of appeal decisions, and to provide standards for transferring an application from an insurance affordability program to the Exchange. Agencies will also develop agreements to share data

between insurance affordability programs. The specific number of agreements needed may vary depending on how states choose to divide responsibilities regarding eligibility determinations.

The burden associated with this provision is the time and effort necessary for the Exchange to establish or modify an agreement for eligibility determinations and coordination of eligibility and enrollment functions. If an Exchange chooses to draft separate agreements for each insurance affordability program or a subset of insurance affordability programs, then the estimate would likely increase. We estimate it will take each Exchange an average of 105 hours to create a new agreement, although we assume that such agreements will be largely standardized across states, and that HHS will provide initial drafts. This includes a mid-level health policy analyst and an operations analyst reviewing the agreement with managerial oversight and comprehensive review of the agreement an operations analyst. We estimate a cost burden of $6,733 per Exchange.

9. ICRs Regarding Notices to QHP Issuers (§§156.260, 156.265, 156.270, 156.290).

First, section 156.260(b) provides that QHP issuers will notify a qualified individual of his or her effective date of coverage, in accordance with the effective dates of coverage established by the Exchange in accordance with §155.410(c) and (f). Second, under §156.270(b), QHP issuers will send a notice of termination of coverage to an enrollee if the enrollee's coverage in the QHP is being terminated for any reason. Third, section 156.270(f) provides that QHP issuers will provide enrollees with a notice about the grace period for non-payment of premiums. QHP issuers will send this notice to enrollees who are delinquent on premium payments. Fourth, section 156.265(e) provides that QHP issuers will provide new enrollees with an enrollment information package, which we anticipate that issuers may combine with the notification of coverage effective date described in §156.260(b). Lastly, under §156.290(b), QHP issuers will provide a notice to enrollees if the issuer elects not to seek recertification of a QHP.

We anticipate that some of the above QHP issuer required notices are similar in nature to the notices that issuers currently send to enrollees. For example, it is standard practice for issuers to provide new enrollees with information about their enrollment in a plan, their effective date of coverage, and if and when their coverage is terminating. Accordingly, we anticipate that QHP issuers will review, update, and revise notice templates that they utilize currently as they work to address the notice requirements described below and to ensure that the notices include the appropriate information. Similar to notices that will be issued by the Exchange, we expect that for QHP-issued notices, an analyst will develop text, and a peer analyst, manager, and legal counsel for the issuer will review the notices, including a review to ensure compliance with plain writing, language access, and readability standards as required under §156.250(c). Finally, a developer will need to incorporate programming changes into the issuer's noticing system to account for the changes and updates that will be necessary to ensure that the QHP issuer is in compliance with the notice standards set forth in this rule and to ensure the notice can be populated and generated according to an individual's preference to receive notices. We estimate that the burden related to the development and implementation of this notice will necessitate 44 hours from a health policy analyst at an hourly cost of $49.35 to learn appeals rules and draft notice text; 20 hours from an attorney at an hourly cost of $90.14 and four hours from a senior manager at an hourly cost of $79.08 to review the notice; and 32 hours from a computer programmer at an hourly cost of $52.50 to conduct the necessary development. In total, we estimate that this will take a total of 100 hours for each QHP issuer, at a cost of approximately $5,971 per issuer. We expect that the burden on QHP issuers to maintain this notice will be significantly lower than to develop it.

However, we believe that the burden estimate described under §155.310(g) likely represents an upper bound estimate of the burden on issuers to develop each of these notices as

in some cases the notice described under §155.310(g) will be somewhat more dynamic in order to address the additional information we expect to be included in that notice.

Since the above estimate applies to one notice, and we described five notices under part 156, the total burden estimate is $40,710. Due to uncertainty regarding the number of individuals who will choose to receive paper notices, as well as some uncertainty regarding the frequency of circumstances that will trigger notices in accordance with this part, we have only included an estimate of the printing and mailing costs for a QHP issuer to send one notice to a qualified individual or enrollee.

We have submitted a copy of this proposed rule to the OMB for its review of the rule's information collection and recordkeeping requirements. These requirements are not effective until they have been approved by the OMB.

10. ICRs Regarding Notices and Third-Party Disclosures in the SHOP (§§157.205(e), 157.205(f))

45 CFR part 157 includes several instances in which qualified employers participating in the SHOP Exchange will need to provide information to employees or to the SHOP Exchange. We include the data elements for these notifications in appendix A of this PRA package. For the individual market Exchange, we anticipate that a large share of enrollees will elect to receive electronic notices while the rest will receive notices by mail. We do not make this assumption for notices described here as we expect that qualified employers will provide notices to employees in whatever format the qualified employer usually provides notices to employees; in paper, electronically, or in a combination of both formats. We estimate that the associated printing costs for paper notices will be approximately $0.10 per notice. We do not take mailing costs into consideration for notices provided by qualified employers, as we expect that if qualified employers provide notices in paper format, the employer may provide the employee with the notice in person, as opposed to mailing the notice. We do not have a reasonable way to

estimate total printing costs for notices provided by qualified employers in the SHOP Exchange due to uncertainty regarding the number of employees who will choose to receive paper notices, as well as some uncertainty regarding the frequency of circumstances that will trigger notices in accordance with this part.

First, §157.205(e) specifies that a qualified employer provide an employee with information about the enrollment process. A qualified employer will inform each employee that he or she has an offer of coverage through the SHOP Exchange, and instructions for how the employee can apply for and enroll in coverage. We anticipate that the qualified employer will also provide information about the acceptable formats in which an employee may submit an application; online, on paper, or by phone, as described under §157.205(c). If the employee being offered coverage was hired outside an initial or annual enrollment period, the notice will also inform the employee if he or she is qualified for a special enrollment period. Second, in §157.205(f) we provide that a qualified employer will notify the SHOP Exchange regarding an employee's change in eligibility for enrollment in a QHP through the SHOP Exchange, including when a dependent or employee is newly eligible, or is no longer eligible.

We expect that the information that qualified employers will provide to employees and the SHOP Exchange, as described above, will be somewhat standardized. Additionally, we anticipate that qualified employers may be more likely to manually develop the notices described in this part, as compared to the other notices described in part 155 and 156 which we anticipate are more likely to be automatically generated. We expect that in order for a qualified employer to establish a notice, the qualified employer will need 20 hours from a human resources specialist at an hourly cost of $40.68 to develop the text; and four hours from a human resources manager at an hourly cost of $75.01 and ten hours from an attorney at an hourly cost of $90.14 to review the notices. We do not anticipate that a developer will be needed to develop the notices described in this part since we expect that in most cases, these notices will be manually

generated on demand. Accordingly, we expect that the burden hours for developing each of the notices will be approximately 34 hours, for a total of 68 hours per qualified employer, at a total cost of $4,030. We expect that the burden on the qualified employer to maintain the notices will be significantly lower than to develop the notices.

D. Summary of Annual Burden Estimates for Proposed Requirements

TABLE 1: Proposed Annual Recordkeeping and Reporting Requirements

Regulation Section(s)	OMB & CMS ID #s	Respondents	Responses (total)	Burden per Response (hours)	Total Annual Burden (hours)	Labor Cost of Reporting ($)	Total Cost ($)
42 CFR 431.10, 431.11, and 457.1120	OCN 0938-New; CMS-10456	48	48	60	2,880	3,258 (per respondent)	156,398
§431.206(b)(4)	OCN 0938-New; CMS-10456	96	96	70	6,720	3,815 (per respondent)	366,221
§§435.917, 435.918, 457.110, and 457.340	OCN 0938-New; CMS-10456	96	96	194	18,624	10,609 (per respondent)	1,018,504
§§435.923 and 457.340 (develop and execute agreements)	OCN 0938-New; CMS-10456	53	1060	12.5	13,250	12,635 (per respondent)	669,644
§§435.923 and 457.340 (create registration process and work flow)	OCN 0938-New; CMS-10456	53	53	70	3,710	3,815 (per respondent)	202,184
§§435.923 and 457.340 (develop training materials)	OCN 0938-New; CMS-10456	53	53	50	2,650	1,710 (per respondent)	90,625
§§435.923 and 457.340 (train application assistors)	OCN 0938-New; CMS-10456	53	53	50	2,650	1,332 (per respondent)	70,596
§§435.1101(b) and 457.355	OCN 0938-New; CMS-10456	53	53	50	2,650	1,710 (per respondent)	90,625
447.57	0938-New; CMS-10456	53	53	6	318	210 (per respondent)	11,130
§§155.225 and 155.227	OCN 0938-New; CMS-10400	51	51	105	5,355	6,733 (per respondent)	343,382
§§ 155.302, 155.225, 155.227, 155.345, 155.510	OCN 0938-New; CMS-10400	51	51	105	5,355	6,733 (per respondent)	343,382

Regulation Section(s)	OMB & CMS ID #s	Respondents	Responses (total)	Burden per Response (hours)	Total Annual Burden (hours)	Labor Cost of Reporting ($)	Total Cost ($)
§§155.302, 155.310, 155.315, 155.320, 155.330, 155.335, 155.345, 155.410, 155.715, 155.722, 155.725, and 155.1080	OCN 0938-New; CMS-10400	51	51	100	5,100	5,971 (per respondent)	304,497
§§155.315, 155. 330, 155.335	OCN 0938-New; CMS-10400	51	51	.2	--	29 (for one respondent)	5.73
§155.320	OCN 0938-New; CMS-10400	1	--	2.2	--	34 (for one respondent)	--
§§155.400, 405, and 430	OCN 0938-New; CMS-10400	51	51	142	7242	7,254 (per respondent)	369,958
§§155.505, 155.510, 155.520, 155.530, 155.535, 155.540, 155.545, 155.550, 155.555, 155.740 (Processing Appeal Request Forms)	OCN 0938-New; CMS-10400	51	279,055	1.5	418,582	243,461 (per respondent)	12,416,553
§§155.505, 155.510, 155.520, 155.530, 155.535, 155.540, 155.545, 155.550, 155.555, 155.740 (Processing Request for Additional Information Forms)	OCN 0938-New; CMS-10400	51	--	1	--	27 (per appellant)	--
§§155.505, 155.510, 155.520, 155.530, 155.535, 155.540, 155.545, 155.550, 155.555, 155.740 (Processing Other Appeals-Related Forms)	OCN 0938-New; CMS-10400	51	--	0.5-1.5	--	10-45 (per appellant)	--
§§155.505, 155.510, 155.520, 155.530, 155.535, 155.540, 155.545, 155.550, 155.555, 155.740 (Creating Agreements (Medicaid, CHIP)	OCN 0938-New; CMS-10400	51	51	105	5,355	6,733 (per respondent)	343,382

Regulation Section(s)	OMB & CMS ID #s	Respondents	Responses (total)	Burden per Response (hours)	Total Annual Burden (hours)	Labor Cost of Reporting ($)	Total Cost ($)
for Appeals)							
§§155.505, 155.510, 155.520, 155.530, 155.535, 155.540, 155.545, 155.550, 155.555, 155.740 (Developing Records Storage System for Appeals)	OCN 0938-New; CMS-10400	51	51	159	8,109	9,159 (per respondent)	467,131
§§155.505, 155.510, 155.520, 155.530, 155.535, 155.540, 155.545, 155.550, 155.555, 155.740 (Developing Appeals-Related Notices)	OCN 0938-New; CMS-10400	51	51	100	5,100	5,971 (per respondent)	304,497
§§156.260, 156.265, 156.270, and 156.290	OCN 0938-New; CMS-10400	51	51	100	5,100	5,971 (per respondent)	304,497
§157.205(e) and (f)	OCN 0938-New; CMS-10400	--	--	68	--	4,030 (per respondent)	--
TOTAL					**518,432**		**17,862,082**

E. Submission of PRA-Related Comments

We have submitted a copy of this proposed rule to OMB for its review of the rule's information collection and recordkeeping requirements. These requirements are not effective until they have been approved by the OMB.

To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, access the CMS Web site at http://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing.html, or call the Reports Clearance Office at 410–786–1326.

We invite public comments on these potential information collection requirements. If you comment on these information collection and recordkeeping requirements, please do either of the following:

1. Submit your comments electronically as specified in the ADDRESSES section of this proposed rule; or

2. Submit your comments to the Office of Information and Regulatory Affairs, Office of Management and Budget, Attention: CMS Desk Officer, (CMS–2334–P) Fax: (202) 395–6974; or E-mail: OIRA_submission@omb.eop.gov. PRA-specific comments must be received by **March 15, 2013**.

VI. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the "DATES" section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

VII. Regulatory Impact Analysis

A. Overall Impact

We have examined the impact of this rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993) and Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011). Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for rules with economically significant effects ($100 million or more in any 1 year). The Office of Management and Budget

has determined that this rulemaking is "economically significant" within the meaning of section 3(f)(1) of Executive Order 12866, because it is likely to have an annual effect of $100 million in any one year. Accordingly, we have prepared a Regulatory Impact Analysis that presents the costs and benefits of this rulemaking. The Department invites comments on this assessment and its conclusions.

In the April 30, 2010, final rule on State Flexibility for Medicaid Benefit Packages, the assumptions utilized in modeling the estimated economic impact of the associated provisions took into perspective the costs of the benefit package for the new adult group. Coverage of these benefits was already accounted for in the April 30, 2010, final rule, and therefore, does not need to be repeated here. A central aim of Title I of the Affordable Care Act is to expand access to health insurance coverage through the establishment of Exchanges. The number of uninsured Americans is rising due to lack affordable insurance, barriers to insurance for people with pre-existing conditions, and high prices due to limited competition and market failures. Millions of people without health insurance use health care services for which they do not pay, shifting the uncompensated cost of their care to health care providers. Providers pass much of this cost to insurance companies, resulting in higher premiums that make insurance unaffordable to even more people. The Affordable Care Act includes a number of policies to address these problems, including the creation of Affordable Insurance Exchanges.

Beginning in 2014, individuals and small businesses will be able to purchase private health insurance –known as qualified health plans-- through competitive marketplaces called Affordable Insurance Exchanges, or "Exchanges." This proposed rule would: (1) Set forth standards for adjudicating appeals of eligibility determinations, including eligibility for enrollment in a qualified health plan through the Exchange and insurance affordability programs, certificates of exemption from the shared responsibility payment, and SHOP eligibility, for purposes of implementing section 1411(f) of the Affordable Care Act; (2) outline criteria related

to the verification of enrollment in an eligible employer-sponsored plan and eligibility for qualifying coverage in an eligible employer-sponsored plan; and (3) further specify or amend other eligibility and enrollment provisions to provide detail necessary for state implementation. This rule continues to afford states substantial discretion in the design and operation of an Exchange, with greater standardization provided where directed by the statute or where there are compelling practical, efficiency or consumer protection reasons.

B. Estimated Impact of the Medicaid and CHIP Eligibility Provisions

The RIA published with the March 2012 Medicaid eligibility final rule detailed the impact of the Medicaid eligibility changes related to implementation of the Affordable Care Act. The majority of provisions included in this proposed rule were described in that detailed RIA.

1. Anticipated Effects on Medicaid Enrollment

The Affordable Care Act's anticipated effects on Medicaid enrollment were described in the March 2012 RIA, with the exception of the new eligibility group for former foster care children. The former foster care group was not covered in the March 2012 rule and therefore was not included in the RIA for that rule. Estimates for this new group are provided below. We note that the estimates included in the March 2012 RIA, and those for the former foster care group, reference the Medicaid baseline for the FY 2013 President's Budget.

As described in Table 2, the CMS Office of the Actuary (OACT) estimates that by 2017, an additional 74,000 individuals will be enrolled in Medicaid under the new eligibility group for former foster care children.

TABLE 2: Estimated Effects of this Proposed Rule on Medicaid Enrollment, 2013-2017 (in thousands)

	2013	2014	2015	2016	2017
Enrollment	0	55	72	73	74

Source: CMS Office of the Actuary.

OACT prepared this estimate using data on individuals, together with their income levels and insured status, from the Current Population Survey and the Medical Expenditure Panel Survey. In addition, they made assumptions as to the actions of individuals in response to the new coverage options under the Affordable Care Act and the operations of the new enrollment processes and the Exchanges. OACT notes that such estimates are inherently uncertain, since they depend on future economic, demographic, and other factors that cannot be precisely determined in advance. Moreover, the actual behavior of individuals and the actual operation of the new enrollment processes and Exchanges could differ from OACT's assumptions.

The net increase in enrollment in the Medicaid program and the resulting reduction in the number of uninsured individuals will produce several benefits. For new enrollees, eligibility for Medicaid will improve access to medical care. Evidence suggests that improved access to medical care will result in improved health outcomes and greater financial security for these individuals and families. Evidence on how Medicaid coverage affects medical care utilization, health, and financial security comes from a recent evaluation of an expansion of Oregon's Medicaid program.[4] In 2008, Oregon conducted a lottery to expanded access to uninsured adults with incomes below 100 percent of the FPL. Approximately 10,000 low-income adults were newly enrolled in Medicaid as a result. The evaluation is particularly strong because it was able to compare outcomes for those who won the lottery with outcomes for those who did not win, and contains an estimate of the benefits of Medicaid coverage. The evaluation concluded that for low-income uninsured adults, Medicaid coverage has the following effects:

- Significantly higher utilization of preventive care (mammograms, cholesterol monitoring, etc.),

4 Amy Finkelstein, et al, "The Oregon Health Insurance Experiment: Evidence from the First Year," National Bureau of Economic Research Working Paper No. 17190, July 2011.

- A significant increase in the probability of having a regular office or clinic for primary care, and
- Significantly better self-reported health.

While there are limitations on the ability to extrapolate from these results to the likely impacts of the Affordable Care Act's expansion of Medicaid coverage, these results provide evidence of health and financial benefits associated with coverage expansions for a population of non-elderly adults.

The results of the Oregon study are consistent with prior research, which has found that health insurance coverage improves health outcomes. The Institute of Medicine (2002) analyzed several population studies and found that people under the age 65 who were uninsured faced a 25 percent higher risk of mortality than those with private coverage. This pattern was found when comparing deaths of uninsured and insured patients from heart attack, cancer, traumatic injury, and HIV infection.[5] The Institute of Medicine also concluded that having insurance leads to better clinical outcomes for diabetes, cardiovascular disease, end-stage renal disease, HIV infection and mental illness, and that uninsured adults were less likely to have regular checkups, recommended health screening services and a usual source of care to help manage their disease than a person with coverage. Other research has found that birth outcomes for women covered by Medicaid are not different than those achieved for privately insured patients, adjusting for risk variables.[6]

In addition to being able to seek treatment for illnesses when they arise, Medicaid beneficiaries will be able to more easily obtain preventive care, which will help maintain and improve their health. Research demonstrates that when uninsured individuals obtain coverage

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5 Institute of Medicine, *Care without coverage: too little, too late* (National Academies Press, 2002).
6 E. A. Anum, et al, "Medicaid and Preterm Birth and Low Birth Weight: The Last Two Decades" Journal of Women's Health Vol. 19 (November 2010).

(including Medicaid), the rate at which they obtain needed care increases substantially.[7 8 9] Having health insurance also provides significant financial security. Comprehensive health insurance coverage provides a safety net against the potentially high cost of medical care, and the presence of health insurance can mitigate financial risk. The Oregon study found people who gained coverage were less likely to have unpaid medical bills referred to a collection agency. Again, this study is consistent with prior research showing the high level of financial insecurity associated with lack of insurance coverage. Some recent research indicates that illness and medical bills contribute to a large and increasing share of bankruptcies in the United States.[10] Another recent analysis found that more than 30 percent of the uninsured report having zero (or negative) financial assets and uninsured families at the 90th percentile of the asset distribution report having total financial assets below $13,000 – an amount that can be quickly depleted with a single hospitalization.[11] Other research indicates that uninsured individuals who experience illness suffer on average a loss of 30 to 50 percent of assets relative to households with insured individuals.[12]

2. Anticipated Effects on States

The major state impacts from this proposed rule were covered in the RIA of the March 2012 Medicaid eligibility final rule. However, OACT estimates that state expenditures on behalf of the additional individuals gaining Medicaid coverage as a result of the establishment of the new eligibility group for former foster care children will total $72 million in FY 2014 and $399 million over five years (2013-2017), as described in Table 3. These estimates do not consider

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7 S.K. Long, et al., "How well does Medicaid work in improving access to care?" HSR: Health Services Research 40:1 (February 2005).
8 Henry J. Kaiser Family Foundation, "Children's Health—Why Health Insurance Matters." Washington, DC: KFF, 2002.
9 C. Keane, et al., "The impact of Children's Health Insurance Program by age," Pediatrics 104:5 (1999).
10 D.U. Himmelstein, et al., "Medical bankruptcy in the United States, 2007: Results of a National Study," The American Journal of Medicine 122 no. 8, (2009).
11 ASPE. The Value of Health Insurance: Few of the Uninsured Have Adequate Resources to Pay Potential Hospital Bills. (2011).

offsetting savings that will result, to a varying degree depending on the state, from less uncompensated care, less need for state-financed health services and coverage programs, and greater efficiencies in the delivery of care.

TABLE 3: Estimated State Budgetary Effects of Increased Medicaid Benefit Spending FY 2013-2017 (in millions of dollars)

	2013	2014	2015	2016	2017	2013-2017
Net Effect on Medicaid Benefit Spending	0	72	101	109	117	399

Source: Office of the Actuary.

Simplifying Medicaid and CHIP eligibility policies, such as by eliminating obsolete and unnecessary eligibility groups and establishing streamlined verification procedures and notice and appeals processes, would reduce administrative burdens for states and for individuals. Medicaid's current patchwork of eligibility rules is complex for states to administer, requiring significant state resources and staff attention. The coordination of Medicaid and CHIP eligibility policy and processes with those of the new Exchanges, including processes to allow for consistency in the provision of notices and appeal rights, and the movement to simplify verification processes with less reliance on paper documentation should all result in a Medicaid eligibility system that is far easier for states to administer than Medicaid's current, more complex system. These changes could generate administrative savings and increase efficiency. The new system through which states will verify certain information with other federal agencies, such as income data from the IRS, will also relieve state Medicaid agencies of some current responsibilities, creating further efficiencies for the states. Currently more than 40 states use an electronic data match with the Social Security Administration in lieu of requiring paper documentation, and many states have found savings from this electronic verification process. In addition, the option to provide electronic notices, combined with coordination of notice

12 Cook, K. et al., "Does major illness cause financial catastrophe?," *Health Services Research* 45, no. 2 (2010).

processes among all insurance affordability programs, may improve consumer access to information while decreasing burden and costs to the states.

These administrative simplifications are expected to lower state administrative costs, although we expect that states may incur short term increases in administrative costs (depending on their current systems and practices) as they implement these changes. The extent of these initial costs will depend on current state policy and practices. Federal support is available to help states finance these system modifications. Notably, in previous rulemaking, CMS increased federal funding to states to better support state efforts to develop significantly upgraded eligibility and enrollment systems. To anticipate and support these efforts, CMS published the Federal Funding for Medicaid Eligibility Determination and Enrollment Activities final rule (75 FR 21950) in the April 19, 2011 **Federal Register**. That rule amended the definition of Mechanized Claims Processing and Information Retrieval Systems to include systems used for eligibility determination, enrollment, and eligibility reporting activities by Medicaid, and made this work eligible for enhanced funding with a federal matching rate of 90 percent for development through 2015 and 75 percent for ongoing maintenance and operations costs. Systems must meet certain standards and conditions in order to qualify for the enhanced match.

3. Anticipated Effects on Providers

As expansion and simplification of Medicaid and CHIP eligibility could result in more individuals obtaining health insurance coverage, health centers, hospitals, clinics, physicians, and other providers are likely to experience a significant increase in their insured patient volume. We expect providers that serve a substantial share of the low-income population to realize the most substantial increase in insured patients. Providers, such as hospitals that serve a low-income population, may financially benefit from having a higher insured patient population and providing less uncompensated care, and the establishment of a presumptive eligibility option for hospitals will further simplify access to coverage for patients. In addition, we expect continuity

of coverage to improve providers' ability to maintain their relationship with patients and to reduce provider administrative burdens such as time spent helping patients to access information on coverage options and to apply for Medicaid or CHIP.

The improved financial security provided by health insurance also helps ensure that patients can pay their medical bills. The Oregon study found that coverage significantly reduces the level of unpaid medical bills sent to a collection agency.[13] Most of these bills are never paid, so this reduction in unpaid bills means that one of the important effects of expanded health insurance coverage, such as the coverage that will be provided through the Exchanges, is a reduction in the level of uncompensated care provided.

Because the majority of individuals gaining coverage under this provision are likely to have been previously uninsured, we do not anticipate that the provisions of this proposed rule will impose new costs on providers. Medicaid generally reimburses providers at a lower rate than employer-sponsored health insurance or other forms of private health insurance. For the minority of individuals who become eligible for Medicaid under this provision who are currently covered by employer-sponsored health insurance, there is thus a possibility that their providers may experience lower payment rates. Conversely, Medicaid generally reimburses federally qualified health centers at a higher rate than employer-sponsored insurance and many new Medicaid enrollees may seek treatment in this setting, which would increase payment to these providers. At the same time, the increased federal financial support for Medicaid, the growth in Medicaid enrollment, and the potential that many plans will operate in both the Exchange and in Medicaid may result in states electing to increase Medicaid payment rates to providers.14

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13 A. Finkelstein, et al., "The Oregon Health Insurance Experiment: Evidence from the First Year," *National Bureau of Economic Research Working Paper Series* No. 17190(2011).

14 D. Bachrach, et al., "Medicaid's role in the Health Benefits Exchange: A road map for States," A Maximizing Enrollment Report, National Academy for State Health Policy and Robert Wood Johnson Foundation (March 2011). Available online at http://www.nashp.org/sites/default/files/maxenroll%20Bachrach%20033011.pdf.

4. Anticipated Effects on Federal Budget

Table 4 presents estimates of the federal budget effect of this rule beyond the impact provided in the March 2012 Medicaid eligibility final rule RIA. The federal financial impact of proposed changes to CHIP will be small; as CHIP expenditures are capped under current law, any increases in spending could be expected to be offset by less available funding in the future. The costs provided below are primarily attributable to the impact of the eligibility group for former foster care children on net federal spending for Medicaid benefits. The impact of other Affordable Care Act provisions was detailed in the prior Medicaid eligibility final rule RIA. As a result of the establishment of the eligibility group for former foster care children, OACT estimates an increase in net federal spending on Medicaid benefits for the period FY 2014 and later, with the increase estimated to be about $95 million in 2014 and about $528 million over the 4-year period from FY 2014 through 2017.

TABLE 4: Estimated Net Increase in Federal Medicaid Benefit Spending, FY 2013-2017 (in millions of dollars)

	2013	2014	2015	2016	2017	2013-2017
Net Effect on Medicaid Benefit Spending	0	95	134	144	155	528

Source: Office of the Actuary.

C. Estimated Impact of the Medicaid Premiums and Cost Sharing Provisions

1. Overall Impact

The changes proposed to Medicaid premiums and cost sharing clarify and update existing flexibilities and provide new flexibility for states to increase beneficiaries' cost sharing obligations. The DRA provided states new authority to implement increased cost sharing and premiums for beneficiaries with incomes above 100 percent of the federal poverty line, but to date, most states have not taken advantage of these flexibilities. As states contemplate the changes required under the Affordable Care Act, more states may consider these authorities, as

well as the new flexibility proposed by these regulations to impose higher copayments for non-preferred drugs and non-emergency use of emergency department services. Based on our policy analysis, we do not anticipate significant costs or savings from these proposed changes at the program level given the targeted nature of the cost sharing. We believe these proposed policies would encourage less costly care and decreased use of unnecessary services, which may reduce state and federal costs for the specified services. In addition, any nominal increase in the beneficiary share of costs would result in a small reduction in the state and federal share of costs. A full analysis by OACT is currently under development.

2. Anticipated Effects

As states better understand their options for imposing premiums and cost sharing, more states may take advantage of existing flexibilities, such as cost sharing of up to 20 percent of the cost of the service, and the option of allowing providers to deny services for unpaid cost sharing, both of which are targeted to somewhat higher income beneficiaries. Research has shown that higher-than-nominal cost sharing on very low-income individuals can have an adverse impact on access to services by discouraging or preventing such individuals from seeking needed care. However, such impacts are not likely to result from the changes proposed here as they are largely focused on services where there are more appropriate and less costly alternatives. Increased cost sharing may have a negative impact on providers, as uncollected cost sharing reduces provider reimbursement, to the extent that the beneficiary cannot or does not pay the cost sharing and services are nonetheless provided. Under the DRA provisions and this proposed rule, however, states may minimize this impact by allowing providers to deny services for failure to pay the required cost sharing in certain circumstances.

D. Estimated Impact of Exchange Provisions

The provisions in this proposed rule amend certain provisions of the Exchange final rule as well as add new provisions, mainly those related to eligibility appeals. Our approach in this

regulatory impact analysis was to build off of the analysis conducted as part of the Exchange final rule, available at http://cciio.cms.gov/resources/files/Files2/03162012/hie3r-ria-032012.pdf, as we do not believe this proposed rule significantly alters the estimates of the impact of Exchanges on the budget or on enrollment in health insurance and therefore does not significantly alter the regulatory impact analysis drafted as part of such rulemaking. This section summarizes benefits and costs of this proposed rule.

1. Methods of Analysis

The estimates in this analysis reflect estimates from the FY 2013 President's Budget for State Planning and Establishment Grants, which incorporate the costs associated with state implementation of the provisions proposed in this rule.

2. Benefits of the Proposed Regulation

This RIA focuses on the effects of the proposed standards implementing the provisions in the Affordable Care Act related to eligibility appeals and other elements of the eligibility and enrollment process. It is difficult to isolate the benefits of these provisions from other provisions related to the establishment and operations of Exchanges and the Affordable Care Act more generally. Moreover, the benefits and costs of the proposed regulation are affected by the other elements of the Exchange Establishment final rule and related policies in the Affordable Care Act. Accordingly, in this section, we provide a discussion of the benefits of increased health coverage, which is the primary impact of the creation of Affordable Insurance Exchanges.

Exchanges are expected to reduce the complexity of information regarding available choices and increase the ability of consumers to easily access insurance. Therefore, we believe, for example, that the eligibility appeals process and the streamlined notice standards included in this proposed rule will support the development and implementation of a streamlined eligibility process, and in doing so, increase enrollment in health insurance.

As discussed in full above regarding the anticipated effect on Medicaid enrollment, the

best available evidence on how health insurance affects medical care utilization, health, and financial security comes from a recent evaluation of an expansion of Oregon's Medicaid program.[15] These same benefits apply to the proposed Exchange provisions which, when taken together with the provisions in the Exchange final rule, will increase access to health coverage. The benefits concluded in the study included significantly better self-reported health.

The regulations proposed here in subparts D and E are consistent with the overall theme of the entire Exchange rule adopted in March 2012, in that they continue to rely on the use of information technology and data matching to minimize administrative burden on applicants, states, and plans. For example, section 155.320(d) of the proposed rule outlines the process to verify enrollment in an eligible employer-sponsored plan and eligibility for qualifying coverage in an eligible employer-sponsored plan. In this section, we specify that the Exchange must first rely on electronic data sources wherever possible, using paper documentation only in situations in which electronic data is unavailable or is not reasonably compatible with the applicant's attestation. Further, in §155.230(d), we propose that the Exchange will provide eligibility notices electronically to the extent that the recipient elects electronic notices. Together, this emphasis on the use of technology in place of paper-driven processes minimizes costs for all involved parties.

Subpart F of the proposed rule outlines standards and processes for Exchange eligibility appeals. For individual eligibility determinations, applicants and enrollees may appeal eligibility determinations made through the eligibility process at the state level, if the state opts to establish an appeals process, or at the federal level, if the state opts not to establish an appeals process or upon exhaustion of a state-based appeals process. An effective eligibility appeals process improves access to health insurance, by providing recourse for issues that arise in the eligibility

15 Finkelstein, A., et al., "The Oregon Health Insurance Experiment: Evidence from the First Year," National Bureau of Economic Research Working Paper Series No. 17190(2011).

process that can disrupt coverage, and also reduces administrative costs, by providing resolution options that enable the vast majority of issues to be resolved by lower-level staff.

The Exchange appeals entity may provide an opportunity for an informal resolution process prior to a hearing, where appellants work with appeals staff to resolve issues, and the proposed appeals process for individuals conducted by HHS will be handled initially through an informal process. If the appellant is not satisfied with the outcome of the informal resolution, he or she has the right to a hearing. The proposed appeals process is based on best practices to provide flexible, transparent, and consumer-centric appeals review and resolution. By providing an efficient, but comprehensive appeals process, the provisions of this proposed rule will ensure accurate and fair appeals of eligibility determinations.

Subpart F of the proposed rule also includes standards for employers related to notices and appeals. Employers will receive notice when an employee is determined eligible for advance payments of the premium tax credit or cost-sharing reductions. This notice indicates that the employer *may* be liable for a penalty through the IRS because the employee has been determined eligible for advance payments of the premium tax credit based, in part, on a determination that the employer does not provide qualifying coverage. Employers may appeal the determination about the nature of the coverage they offer to employees to the Exchange before the penalty is imposed by the IRS. We propose that employer appeals will be conducted through a record review. States may choose to establish an employer appeals process, or HHS will provide such a process if a state fails to do so. However, unlike the individual appeals process, we propose that employers will not elevate an appeal decision by a state-based Exchange appeals entity to the HHS process.

Subpart H includes standards for SHOP eligibility appeals. We propose that employers and employees will have a similar system for appealing denials of eligibility by the SHOP. These appeals will be conducted through a record review by the appeals entity. Any state that

chooses to operate an Exchange will also operate a SHOP and provide a SHOP eligibility appeals process. HHS will handle SHOP eligibility appeals in the federally-facilitated SHOP. SHOP appellants do not have the option to elevate state-based SHOP appeal decisions to HHS. By providing a separate appeals process for small businesses, the provisions of this proposed rule will help ensure accurate and satisfactory determinations are made for small businesses complying with their responsibilities as defined in the Affordable Care Act.

3. Costs of the Proposed Regulation

The Affordable Care Act and the implementing regulations found in subpart D of the proposed rule provide for a streamlined system based on simplified eligibility rules, and an expedited process that will enhance enrollment of eligible individuals and minimize costs to states, Exchanges and to the federal government. To support this new eligibility structure, states seeking to operate Exchanges are expected to build new or modify existing information technology (IT) systems. We believe that how each state constructs and assembles the components necessary to support its Exchange and Medicaid infrastructure will vary and depend on the level of maturity of current systems, current governance and business models, size, and other factors. It is important to note that, although states have the option to establish and operate an Exchange, there is no federal requirement that each state establish an Exchange. We believe the proposed provisions provide options and flexibility to states that minimize costs and burden on Exchanges, consumers, employers and other entities. We also believe that overall administrative costs may increase in the short term as states build IT systems; however, in the long term, states may see savings through the use of more efficient systems.

Any administrative costs incurred in the development of IT infrastructure to support the Exchange may be funded through Exchange Planning and Establishment Grants to states. The federal government expects that these grants will fund the development of IT systems that can be used by many states who either develop their own Exchanges or who partner with the federal

government to provide a subset of Exchange services.[16] Costs for IT infrastructure that will also support Medicaid must be allocated to Medicaid, but are eligible for a 90 percent federal matching rate to assist in development.[17]

In addition to costs associated with IT infrastructure, potential costs associated with this proposed rule relate to the appeals process. States that form their own appeals entities will incur costs of staff labor to conduct informal resolution proceedings, if a state voluntarily takes up the option to offer informal resolution, and to conduct hearings. Other costs will be borne by HHS when hearing appeals for states without a state-based appeals entity, or when hearing secondary appeals from individuals who have exhausted their state-based appeals process. In addition, costs will be borne by HHS and state-based Exchange appeals entities when adjudicating employer and SHOP appeals. However, the proposed rule is designed to facilitate the ability of states to choose to consolidate appeals operations with similar functions that exist today for Medicaid and CHIP, which could reduce one-time and ongoing costs.

In general, as noted in our discussion of benefits, we anticipate that the proposed rule would increase take-up of health insurance; therefore, one type of rule-induced cost would be associated with providing additional medical services to newly-enrolled individuals. A recent study found that insured individuals received more hospital care and more outpatient care than their uninsured counterparts.[18]

Below we include estimated federal government payments related to grants for Exchange startup. States' initial costs due to the creation of Exchanges will be funded by these grants. Eligibility determination is a minimum function of the Exchange; therefore the Exchange costs

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16 For example, CMS has awarded a number of Early Innovator grants to develop efficient and replicable IT systems that can provide the foundation for other states' work in this area. These amounts vary from $6 million to $48 million per state.

17 Federal Funding for Medicaid Eligibility Determination and Enrollment Activities. Final Rule. April 19, 2011 [42 CFR Part 433, 75 FR 68583, pg 21950]

to develop the infrastructure for the provisions included in this proposed rule are covered by these grant outlays.

TABLE 5: Estimated Federal Government Outlays for the Affordable Insurance Exchanges FY 2013 - FY2017, in billions of dollars

Year	2013	2014	2015	2016	2017	2013-2017
Grant Authority for Exchange Start up[a]	1.1	0.8	0.4	0.1	0.01	2.41

[a] FY 2013 President's Budget

E. Alternatives Considered

The majority of Medicaid and CHIP eligibility provisions proposed in this rule serve to implement the Affordable Care Act. All of the provisions in this final rule are a result of the recent passage of the Affordable Care Act and are largely self-implementing. Therefore, alternatives considered for this proposed rule were constrained due to the statutory provisions. With publication of this proposed rule, we desire to make our implementing regulations available to states and the public as soon as possible to facilitate continued efficient operation of the state flexibility authorized under section 1937 of the Act.

In developing this rule, we considered alternatives to some of the simplified eligibility policies proposed here, as well as to the streamlined, coordinated process and eligibility policies this rule established between Medicaid, the Exchange, and other insurance affordability programs. One alternative would be to allow Medicaid agencies to provide notices to individuals independently of the notices provided by other insurance affordability programs. This option would allow states to maintain current Medicaid notice practices, but could result in multiple communications from different entities regarding each individual's eligibility determination process. This could create significant confusion for applicants and beneficiaries.

[18] Finkelstein, A. et al., (2011). The Oregon Health Insurance Experiment: Evidence from the First Year," *National Bureau of Economic Research Working Paper Series*, 17190.

Another alternative would be to consolidate all notice responsibilities within the Exchanges and require one clear line of communication between applicants and the entities determining eligibility for insurance affordability programs. However, this would reduce state flexibility relative to the flexibility already offered in the prior Medicaid eligibility rule and would mandate significant coordination among insurance affordability programs that could stretch beyond just the provision of notices.

In developing the provisions related to Medicaid premiums and cost sharing, we considered maintaining the current structure of the regulations and limiting proposed changes to simple updates of maximum nominal cost sharing amounts. However, the current structure, with its duplicative and sometimes overlapping provisions, makes it much more difficult for states to establish a simple, straightforward cost sharing policy. We believe the proposed approach will assist states, providers, and beneficiaries in understanding their obligations.

We considered three alternatives on Exchange provisions.

- Alternative #1: Establish only a federal appeals process

States are not required to establish an Exchange, and those that do not will rely on a federally-facilitated Exchange. States that do form a state-based Exchange likewise have the option to establish a state-based Exchange appeals entity; however, states without an appeals process may rely on the HHS appeals process for individual and employer appeals. If states do form a state-based appeals entity, HHS will serve as a second level of appeal for individuals unsatisfied with the outcome of their state-based Exchange appeal. All state-based Exchanges must establish an appeals process for employers and employees in the SHOP. One alternative considered was to establish only a federal appeals process, as prescribed in statute, and not to offer state-based Exchanges the option to establish their own appeal programs. However, this alternative was not selected because it would limit state flexibility, and negate the administrative efficiencies available through the use of existing appeals processes.

- Alternative #2: Require paper documentation to verify access to employer-sponsored coverage.

Section 155.320(d) of the proposed rule provides a process for verification related to enrollment in an eligible employer-sponsored plan and eligibility for qualifying coverage in an eligible employer-sponsored plan. The proposed process relies on available electronic data sources, with the use of paper documentation in situations in which information submitted by an applicant is not reasonably compatible with information in electronic data sources, along with a sample-based review for situations in which no data is available.

The alternative model would require the Exchange to require individuals to submit paper documentation to verify this information. This would not only increase the burden on individuals to identify and collect this information, which may not be readily available to the applicant, but on employers, who would have to produce this information at the request of applicants, and would also require additional time and resources for Exchanges to accept and process the paper documentation needed for an eligibility determination. In addition, it could ultimately increase the amount of time it would take for an individual to receive health coverage through the Exchange or an insurance affordability program, would reduce the number of states likely to operate an Exchange due to increased administrative costs, and would dissuade individuals from seeking coverage through the Exchange.

- Alternative #3: Require Paper Notices

In §155.230(d), we provide that the Exchange will provide the option to an individual or employer to receive notices electronically. We anticipate that this will be accommodated by the Exchange generating electronic notices, storing them on a secure website, and notifying individuals and employers through a generic e-mail or text message communication that a notice is available for review.

The alternative model would require the Exchange to send all notices via US mail. This

would significantly increase administrative costs for printing and mailing, and also generate significant volumes of undeliverable mail which would be returned to the Exchange.

Summary of Costs for Each Alternative

Alternative 1 would add additional costs as it does not allow the use of existing state resources to administer appeals. The paper-driven process outlined under alternatives 2 and 3 would ultimately increase the amount of time it would take for an individual to receive health coverage through the Exchange or an insurance affordability program, would increase administrative costs, and would dissuade individuals from seeking coverage through the Exchange.

F. Limitations of the Analysis

A number of challenges face estimators in projecting Medicaid and CHIP benefits and costs under the Affordable Care Act and the proposed rule. Health care cost growth is difficult to project, especially for people who are currently not in the health care system – the population targeted for the Medicaid eligibility changes. Such individuals could have pent-up demand and thus have costs that may be initially higher than other Medicaid enrollees, while they might also have better health status than those who have found a way (for example, "spent down") to enroll in Medicaid.

There is also considerable uncertainty about behavioral responses to the Medicaid and CHIP changes. Individuals' participation rates are particularly uncertain. Medicaid participation rates for people already eligible tend to be relatively low (estimates range from 75 to 86 percent), despite the fact that there are typically no premiums and low to no cost sharing for comprehensive services. It is not clear how the proposed changes will affect those already eligible, or the interest in participating for those newly eligible, as previously described.

G. Accounting Statement

As required by OMB Circular A-4 (available at http://www.whitehouse.gov/omb/circulars_a004_a-4/), in Table 6 we have prepared an accounting statement table showing the classification of the impacts associated with implementation of this proposed rule.

TABLE 6: Accounting Statement: Classification of Estimated Net Costs, from FY 2013 to FY 2017 (in millions)

Category	Estimates	Units		
		Year Dollar	Discount Rate	Period Covered
Benefits				
Annualized Monetized ($million/year)	Not Estimated	2012	7%	2013 - 2017
	Not Estimated	2012	3%	2013 - 2017
Qualitative	The Exchanges, combined with other actions being taken to implement the Affordable Care Act, will improve access to health insurance, with numerous positive effects, including reduced morbidity and fewer bankruptcies. The Exchange will also serve as a distribution channel for insurance reducing administrative costs as a part of premiums and providing comparable information on health plans to allow for a more efficient shopping experience.			
Costs*				
Annualized Monetized ($million/year)	521	2012	7%	2013 - 2017
	499	2012	3%	2013 - 2017
Qualitative	Unquantified costs include State implementation costs above the amount covered by Federal grants, costs associated with hearings, and increased medical costs associated with more widespread enrollment in health insurance.			
Transfers**				
Annualized	101	2012	7%	2013 - 2017

Monetized ($million/year)	103	2012	3%	2013 - 2017
From Whom to Whom	The transfers is from Federal Government to States on Behalf of Beneficiaries			
Annualized Monetized ($million/year)	76	2012	7%	2013 – 2017
	78	2012	3%	2013 - 2017
From Whom to Whom	The transfers is from States on Behalf of Beneficiaries			

*These costs include grant outlays to States to establish Exchanges; most of these Exchange-establishment costs been included in the accounting statement for the Exchange final rule.
** Source: Office of the Actuary

H. Regulatory Flexibility Analysis

The Regulatory Flexibility Act (5 U.S.C. 601 et seq.) (RFA) requires agencies to prepare an initial regulatory flexibility analysis to describe the impact of the proposed rule on small entities, unless the head of the agency can certify that the rule will not have a significant economic impact on a substantial number of small entities. The Act generally defines a "small entity" as (1) a proprietary firm meeting the size standards of the Small Business Administration (SBA); (2) a not-for-profit organization that is not dominant in its field; or (3) a small government jurisdiction with a population of less than 50,000. States and individuals are not included in the definition of "small entity." HHS uses as its measure of significant economic impact on a substantial number of small entities a change in revenues of more than 3 to 5 percent.

As discussed above, this proposed rule is necessary to implement certain standards related to the establishment and operation of Exchanges as authorized by the Affordable Care Act. Specifically, this proposed rule would: (1) set forth standards for adjudicating appeals of eligibility determinations, including eligibility for enrollment in a QHP through the Exchange and insurance affordability programs, certificates of exemption from the shared responsibility payment, and SHOP eligibility, for purposes of implementing section 1411(f) of the Affordable

Care Act, (2) outline criteria related to the verification of enrollment in an eligible employer-sponsored plan and eligibility for qualifying coverage in an eligible employer-sponsored plan, and (3) further specify or amend standards related to other eligibility and enrollment provisions to provide detail necessary for state implementation.

The intent of this rule is to continue to afford states substantial discretion in the design and operation of an Exchange, with greater standardization provided where directed by the statute or where there are compelling practical, efficiency or consumer protection reasons.

For the purposes of the regulatory flexibility analysis, we expect the following types of entities to be affected by this proposed rule--(1) QHP issuers; and (2) employers. We believe that health insurers would be classified under the North American Industry Classification System (NAICS) Code 524114 (Direct Health and CMS–9989-P 166 Medical Insurance Carriers). According to SBA size standards, entities with average annual receipts of $7 million or less would be considered small entities this NAICS code. Health issuers could also possibly be classified in 621491 (HMO Medical Centers) and, if this is the case, the SBA size standard would be $10 million or less.

QHP Issuers

This rule proposes standards for Exchanges that affect eligibility determinations for enrollment in a QHP, advance payments of the premium tax credit, cost-sharing reductions, Medicaid, and CHIP. Although these standards are for Exchanges, they also affect health plan issuers that choose to participate in an Exchange. QHP issuers receive information from an Exchange about an enrollee in order to enable the QHP issuer to provide the correct level of advance payments of the premium tax credit and cost-sharing reductions. The issuer of the QHP will adjust an enrollee's net premium to reflect the advance payments of the premium tax credit, as well as make any changes required to ensure that cost-sharing reflects the appropriate level of reductions. Issuers benefit significantly from advance payments of the premium tax credit and

cost-sharing reductions, but may face some administrative costs relating to receiving enrollee information from an Exchange.

As discussed in the Web Portal interim final rule (75 FR 24481), HHS examined the health insurance industry in depth in the Regulatory Impact Analysis we prepared for the proposed rule on establishment of the Medicare Advantage program (69 FR 46866, August 3, 2004). In that analysis we determined that there were few, if any, insurance firms underwriting comprehensive health insurance policies (in contrast, for example, to travel insurance policies or dental discount policies) that fell below the size thresholds for "small" business established by the SBA (currently $7 million in annual receipts for health insurers, based on North American Industry Classification System Code 524114).[19]

Additionally, as discussed in the Medical Loss Ratio interim final rule (75 FR 74918), the Department used a data set created from 2009 National Association of Insurance Commissioners (NAIC) Health and Life Blank annual financial statement data to develop an updated estimate of the number of small entities that offer comprehensive major medical coverage in the individual and group markets. For purposes of that analysis, the Department used total Accident and Health (A&H) earned premiums as a proxy for annual receipts. The Department estimated that there were 28 small entities with less than $7 million in accident and health earned premiums offering individual or group comprehensive major medical coverage; however, this estimate may overstate the actual number of small health insurance issuers offering such coverage, because it does not include receipts from these companies' other lines of business.

Employers

The establishment of SHOP in conjunction with tax incentives for some employers will provide new opportunities for employers to offer affordable health insurance to their employees.

'Table of Size Standards Matched To North American Industry Classification System Codes,'' effective November 5, 2010, U.S. Small Business Administration, available at http://www.sba.gov.

A detailed discussion of the impact on employers related to the establishment of the SHOP is found in the RIA for the Exchange final rule, available at http://cciio.cms.gov/resources/files/Files2/03162012/hie3r-ria-032012.pdf

Subpart F of part 155 proposes to establish an appeals process through which an employer may appeal a determination that the employer does not provide qualifying coverage in an eligible employer-sponsored plan with respect to the employee referenced in the notice pursuant to section 1411(f)(2) of the Affordable Care Act, or an eligibility determination for SHOP. This rule proposes standards for employers that choose to participate in a SHOP. The SHOP is limited by statute to employers with at least one but not more than 100 employees. For this reason, we expect that many employers would meet the SBA standard for small entities. However, since participation in the SHOP is voluntary, this proposed rule does not place any requirements on small employers.

We request comment on whether the small entities affected by this rule have been fully identified. We also request comment and information on potential costs for these entities and on any alternatives that we should consider.

Except in the Exchange provisions, few of the entities that meet the definition of a small entity as that term is used in the RFA (for example, small businesses, nonprofit organization, and small governmental jurisdictions with a population of less than 50,000) would be impacted directly by this proposed rule. Individuals and states are not included in the definition of a small entity. In addition, the impact of the majority of this rule was addressed in the RIA accompanying the March 2012 Medicaid eligibility rule. Therefore, the Secretary has determined that this final rule will not have a significant economic impact on a substantial number of small entities, and we have not prepared a regulatory flexibility analysis.

Additionally, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a proposed rule may have a significant economic impact on the operations of a

substantial number of small rural hospitals. This analysis must conform to the provisions of section 603. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a metropolitan statistical area and has fewer than 100 beds. We are not preparing an analysis for section 1102(b) of the Act because the Secretary has determined that this proposed rule would not have a direct economic impact on the operations of a substantial number of small rural hospitals.

I. Unfunded Mandates

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation, by state, local, or tribal governments, in the aggregate, or by the private sector. Currently, that threshold is approximately $139 million. This final rule does not mandate expenditures by state governments, local governments, tribal governments, in the aggregate, or the private sector, of $139 million. The majority of state, local, and private sector costs related to implementation of the Affordable Care Act were described in the RIA accompanying the March 2012 Medicaid eligibility rule. Furthermore, the proposed rule does not set any mandate on states to set up an Exchange,

J. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule that imposes substantial direct effects on states, preempts state law, or otherwise has federalism implications. We wish to note again that the impact of changes related to implementation of the Affordable Care Act were described in the RIA of the March 2012 Medicaid eligibility rule. As discussed in the March 2012 RIA, we have consulted with states to receive input on how the various Affordable Care Act provisions codified in this proposed rule would affect states. We continue to engage in ongoing consultations with

Medicaid and CHIP Technical Advisory Groups (TAGs), which have been in place for many years and serve as a staff level policy and technical exchange of information between CMS and the states. Through consultations with these TAGs, we have been able to get input from states specific to issues surrounding the changes in eligibility groups and rules that will become effective in 2014.

Because states have flexibility in designing their Exchange, state decisions will ultimately influence both administrative expenses and overall premiums. However, because states are not required to create an Exchange, these costs are not mandatory. For states electing to create an Exchange, the initial costs of the creation of the Exchange will be funded by Exchange Planning and Establishment Grants. After this time, Exchanges will be financially self-sustaining with revenue sources left to the discretion of the state. In the Department's view, while this proposed rule does not impose substantial direct on state and local governments, it has federalism implications due to direct effects on the distribution of power and responsibilities among the state and federal governments relating to determining standards relating to health insurance coverage (that is, for QHPs) that is offered in the individual and small group markets. Each state electing to establish a state-based Exchange must adopt the federal standards contained in the Affordable Care Act and in this proposed rule, or have in effect a state law or regulation that implements these federal standards. However, the Department anticipates that the federalism implications (if any) are substantially mitigated because states have choices regarding the structure and governance of their Exchanges. Additionally, the Affordable Care Act does not require states to establish an Exchange; but if a state elects not to establish an Exchange or the state's Exchange is not approved, HHS, will establish and operate an Exchange in that state. Additionally, states will have the opportunity to participate in state Partnership Exchanges that would allow states to leverage work done by other states and the federal government.

In compliance with the requirement of Executive Order 13132 that agencies examine

closely any policies that may have federalism implications or limit the policy making discretion of the states, the Department has engaged in efforts to consult with and work cooperatively with affected states, including participating in conference calls with and attending conferences of the National Association of Insurance Commissioners, and consulting with state officials on an individual basis.

Pursuant to the requirements set forth in section 8(a) of Executive Order 13132, and by the signatures affixed to this regulation, the Department certifies that CMS has complied with the requirements of Executive Order 13132 for the attached proposed regulation in a meaningful and timely manner.

K. Congressional Review Act

This proposed rule is subject to the Congressional Review Act provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801 et seq.), which specifies that before a rule can take effect, the federal agency promulgating the rule shall submit to each House of the Congress and to the Comptroller General a report containing a copy of the rule along with other specified information, and has been transmitted to Congress and the Comptroller General for review.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

List of Subjects

42 CFR Part 430

Administrative practice and procedure, Grant programs-health, Medicaid Reporting and recordkeeping requirements.

42 CFR Part 431

Grant programs-health, Health facilities, Medicaid, Privacy, Reporting and recordkeeping requirements.

42 CFR Part 433

Administrative practice and procedure, Child support Claims, Grant programs-health, Medicaid, Reporting and recordkeeping requirements.

42 CFR Part 435

Aid to Families with Dependent Children, Grant programs-health, Medicaid, Reporting and recordkeeping requirements, Supplemental Security Income (SSI), Wages.

42 CFR Part 440

Grant programs-health, Medicaid.

42 CFR Part 447

Accounting, Administrative practice and procedure, Drugs, Grant programs-health, Health facilities, Health professions, Medicaid, Reporting and recordkeeping requirements, Rural areas.

42 CFR Part 457

Administrative practice and procedure, Grant programs-health, Health insurance, Reporting and recordkeeping requirements.

45 CFR Part 155

Administrative practice and procedure, Advertising, Brokers, Conflict of interest, Consumer protection, Grant programs-health, Grants administration, Health care, Health

insurance, Health maintenance organization (HMO), Health records, Hospitals, Indians, Individuals with disabilities, Loan programs-health, Organization and functions (Government agencies), Medicaid, Public assistance programs, Reporting and recordkeeping requirements, Safety, state and local governments, Technical assistance, Women, and Youth.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services proposes to amend 42 CFR chapter IV as set forth below:

PART 430—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

1. The authority citation for part 430 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

2. Section 430.12 is amended by revising paragraph (a) to read as follows:

§430.12 Submittal of State plans and plan amendments.

(a) Format. A State plan for Medicaid consists of a standardized automated template, issued and periodically updated by CMS, that includes both basic requirements and individualized content that reflects the characteristics of the State's program.

(1) States with approved paper State plans shall submit plans to comply with the required automated format with full compliance not later than one year following the availability of the automated template.

(2) Thereafter, approved paper State plans or plan amendments shall be valid only temporarily to the extent specifically authorized and incorporated by reference under the approved automated State plan.

* * * * *

PART 431--STATE ORGANIZATION AND GENERAL ADMINISTRATION

3. The authority citation for part 431 continues to read as follows:

Authority: Sec**.** 1102 of the Social Security Act, (42 U.S.C. 1302).

4. Section 431.10 is amended by --

A. Revising paragraphs (a), (c), (d), and (e).

B. Adding paragraph (b)(3).

The revisions and additions read as follows:

§431.10 Single State agency.

(a) Basis, purpose, and definitions. (1) This section implements section 1902(a)(4) and (5) of the Act.

(2) For purposes of this part –

Appeals decision means a decision made by a hearing officer adjudicating a fair hearing under subpart E of this part, including by a hearing officer employed an Exchange appeals entity to which the agency has delegated authority to conduct such hearings under this section.

Exchange has the meaning given to the term in 45 CFR 155.20.

Exchange appeals entity has the meaning given to the term "appeals entity," as defined in 45 CFR 155.500.

Medicaid agency is the single State agency for the Medicaid program.

(b) * * *

(3) The single State agency is responsible for determining eligibility for all individuals applying for or receiving benefits in accordance with regulations in part 435 of this chapter and for fair hearings filed in accordance with subpart E of this part.

(c) Delegations. (1) Subject to the requirement in paragraph (c)(2) of this section, the Medicaid agency may, in the approved state plan–

(i)(A) Delegate authority to determine eligibility for all or a defined subset of individuals to—

(1) The single State agency for the financial assistance program under title IV-A (in the 50 States or the District of Columbia), or under title I or XVI (AABD), in Guam, Puerto Rico, or the Virgin Islands;

(2) The Federal agency administering the supplemental security income program under title XVI of the Act; or

(3) The Exchange.

(B) The plan must specify to which agency or public authority and the individuals with respect to which, authority to determine eligibility is delegated.

(ii) Delegate authority to conduct fair hearings in accordance with subpart E of this part for denials of eligibility based on the applicable modified adjusted gross income standard, as described in §435.911 of this chapter, to an Exchange or Exchange appeals entity, provided that individuals who have requested a fair hearing of such a denial are given the choice to have their fair hearing conducted by the Medicaid agency or the Exchange or Exchange appeals entity.

(2) The Medicaid agency may delegate authority to make eligibility determinations or to conduct fair hearings under this section only to a government agency or public authority which maintains personnel standards on a merit basis.

(3) The Medicaid agency –

(i) Must ensure that any agency or public authority to which eligibility determinations or appeals decisions are delegated –

(A) Complies with all relevant Federal and State law, regulations and policies, including, but not limited to, those related to the eligibility criteria applied by the agency under part 435 of this chapter; prohibitions against conflicts of interest and improper incentives; and safeguarding confidentiality, including regulations set forth at subpart F of this part.

(B) Informs applicants and beneficiaries how they can directly contact and obtain information from the agency; and

(ii) Must exercise appropriate oversight over the eligibility determinations and appeals decisions made by such agencies to ensure compliance with paragraphs (c)(2) and (c)(3)(i) of this section and institute corrective action as needed, including, but not limited to, rescission of the authority delegated under this section.

(iii) If authority to conduct fair hearings is delegated to the Exchange or Exchange

appeals entity under paragraph (c)(1)(ii) of this section, the agency may establish a review process whereby the agency reviews appeals decisions made by the Exchange or Exchange appeals entity, but only with respect to conclusions of law, including interpretations of State or Federal requirements.

(d) Agreement with Federal, State or local entities making eligibility determinations or appeals decisions. The plan must provide for written agreements between the Medicaid agency and the Exchange or any other State or local agency that has been delegated authority under paragraph (c)(1)(i) of this section to determine Medicaid eligibility and for written agreements between the agency and the Exchange or Exchange appeals entity that has been delegated authority to conduct Medicaid fair hearings under paragraph (c)(1)(ii) of this section. Such agreements must be available to the Secretary upon request and must include provisions for:

(1) The relationships and respective responsibilities of the parties, including but not limited to the respective responsibilities to effectuate the fair hearing rules in subpart E of this part;

(2) Quality control and oversight by the Medicaid agency, including any reporting requirements needed to facilitate such control and oversight;

(3) Assurances that the entity to which authority to determine eligibility or conduct fair hearings will comply with the provisions set forth in paragraph (c)(3) of this section.

(4) For appeals, procedures to ensure that individuals have notice and a full opportunity to have their fair hearing conducted by either the Exchange or Exchange appeals entity or the Medicaid agency.

(e) Authority of the single State agency. The Medicaid agency may not delegate, to other than its own officials, the authority to supervise the plan or to develop or issue policies, rules, and regulations on program matters.

5. Section 431.11 is amended by --

A. Removing paragraph (b).

B. Redesignating paragraphs (c) and (d), as paragraphs (b) and (c), respectively.

C. Revising newly redesignated paragraphs (b) and (c).

The revisions read as follows:

§431.11 Organization for administration.

* * * * *

(b) Description of organization. The plan must include a description of the organization and functions of the Medicaid agency.

(c) Eligibility determined or appeals decided by other entities. If eligibility is determined or appeals decided by Federal or State entities other than the Medicaid agency or by local agencies under the supervision of other State agencies, the plan must include a description of the staff designated by those other entities and the functions they perform in carrying out their responsibilities.

6. Section 431.200 is amended by adding paragraph (d) to read as follows:

§431.200 Basic and scope.

* * * * *

(d) Implements section 1943(b)(3) of the Act and section 1413 of the Affordable Care Act to permit coordinated hearings and appeals among insurance affordability programs.

7. Section 431.201 is amended by --

A. Revising the definition of "Action."

B. Adding the definition of "Local evidentiary hearing" in alphabetical order

The revisions and addition to read as follows:

§431.201 Definitions.

* * * * *

Action means a termination, suspension, or reduction of Medicaid eligibility or a reduction in the level of benefits and services, including a determination of the amount of medical expenses which must be incurred to establish income eligibility in accordance with §435.121(e)(4) or §435.831 of this chapter, or a determination of income for the purposes of imposing any premiums, enrollment fees, or cost-sharing under subpart A of part 447 of this chapter. It also means determinations by skilled nursing facilities and nursing facilities to transfer or discharge residents and adverse determinations made by a State with regard to the preadmission screening and resident review requirements of section 1919(e)(7) of the Act.

* * * * *

Local evidentiary hearing means a hearing held on the local or county level serving a specified portion of the State.

* * * * *

8. Section 431.205 is amended by --

A. Revising paragraphs (b)(1)and (b)(2).

B. Adding paragraph (e).

The revisions and additions read as follows:

§431.205 Provision of hearing system.

* * * * *

(b) * * *

(1) A hearing before –

(i) The Medicaid agency; or

(ii) For the denial of eligibility based on the applicable modified adjusted gross income standard, the Exchange or Exchange appeals entity to which authority to conduct fair hearings under this subpart has been delegated under §431.10(c)(1)(ii) of this subpart, provided that

individuals who have requested a fair hearing are given the choice to have their fair hearing conducted by the agency or the Exchange or Exchange appeals; or

(2) An evidentiary hearing at the local level, with a right of appeal to the Medicaid agency.

* * * * *

(e) The hearing system must be accessible to persons who are limited English proficient and persons who have disabilities, consistent with §435.905(b) of this chapter.

9. Section 431.206 is amended by--

A. Revising paragraph (b) introductory text and paragraph (c)(2).

B. Adding paragraphs (d) and (e).

The revisions and additions read as follows:

§ **431.206 Informing applicants and beneficiaries.**

* * * * *

(b) The agency or entity taking action must, at the time specified in paragraph (c) of this section, inform every applicant or beneficiary in writing—

* * * * *

(c) * * *

(2) At the time the agency or entity denies eligibility or services, or takes other action affecting the individual's eligibility, level of benefits and services, or claims;

* * * * *

(d) If, in accordance with §431.10(c)(1)(ii) of this part, the agency has delegated authority to the Exchange or Exchange appeals entity to conduct the fair hearing, that the individual has the right to have his or her hearing before the agency, Exchange or the Exchange appeals entity, and the method by which the individual may make such election.

(e) The information required under this section must be accessible to individuals who are

limited English proficient and to individuals with disabilities, consistent with §435.905(b) of this chapter, and may be provided in electronic format in accordance with §435.918 of this chapter.

10. Section 431.210 is amended by revising paragraphs (a), (b), and (d)(1) to read as follows:

§431.210 Content of notice.

* * * * *

(a) A Statement of what action the agency, skilled nursing facility, or nursing facility intends to take and the effective date of such action;

(b) A clear Statement of the specific reasons supporting the intended action;

* * * * *

(d) * * *

(1) The individual's right to request a local evidentiary hearing if one is available, or a State agency hearing; or

* * * * *

11. Section 431.211 is revised to read as follows:

§431.211 Advance notice.

The State or local agency must send a notice at least 10 days before the date of action, except as permitted under §431.213 and §431.214 of this part.

12. Section 431.213 is amended by revising the introductory text to read as follows:

§431.213 Exceptions from advance notice.

The agency may send a notice not later than the date of action if --

* * * * *

13. Section 431.220 is amended by revising paragraph (a)(1) to read as follows:

§431.220 When a hearing is required.

(a) * * *

(1) Any applicant who requests it because the agency denies his or her eligibility, level of benefits, services or claims, or such claim is not acted upon with reasonable promptness including, if applicable --

(i) A determination of the amount of medical expenses which must be incurred to establish eligibility in accordance with §435.121(e)(4) or §435.831 of this part; or

(ii) A determination of income for the purposes of imposing any premiums, enrollment fees, and cost sharing under subpart A of part 447 of this chapter.

* * * * *

14. Section 431.221 is amended by --

A. Revising paragraph (a).

B. Adding paragraph (e).

The revisions and additions read as follows:

§431.221 Request for hearing.

(a) The agency must establish procedures that permit an individual, or an authorized representative acting on behalf of an individual to submit a hearing request:

(1) By telephone;

(2) Via mail;

(3) In person;

(4) Through other commonly available electronic means; and

(5) Via the internet website described in §435.1200(f) of this chapter, at State option.

* * * * *

(e) If an individual has been denied eligibility for Medicaid by the agency or other entity authorized, in accordance with §431.10(c)(1) of this part, to make such determination, the agency must treat an appeal to the Exchange appeals entity of a determination of eligibility for

advanced payments of the premium tax credit or cost-sharing reduction, as a request for a hearing, under this section.

15. Section 431.224 is added to read as follows:

§431.224 Expedited appeals.

(a) General rule. The agency must establish and maintain an expedited review process for hearings, when an individual requests or a provider requests, or supports the individual's request, that the time otherwise permitted for a hearing could jeopardize the individual's life or health or ability to attain, maintain, or regain maximum function.

(b) Action following denial of a request for expedited hearing. If the agency denies a request for an expedited appeal, it must--

(1) Use the standard appeal timeframe, in accordance with §431.244(f)(1) of this part.

(2) Notify the individual orally or through electronic means of the denial and, if oral notification is provided, follow up with written notice within 2 calendar days of the denial. Provision of electronic notice must be consistent with §435.918 of this subchapter.

§431.230 [Amended]

16. In § 431.230, amend paragraph (a) by removing the term "mails" and adding in its place the term "sends."

17. Section 431.231 is amended by revising the section heading and paragraph (c)(2) to read as follows:

§431.231 Reinstating services.

* * * * *

(c) * * *

(2) The beneficiary requests a hearing within 10 days that the individual receives the notice of action. The date on which the notice is received is considered to be 5 days after the

date on the notice, unless the beneficiary shows that he or she did not receive the notice within the 5-day period; and

* * * * *

18. Section 431.232 is amended by revising the introductory language and paragraph (b) to read as follows:

§431.232 Adverse decision of local evidentiary hearing.

If the decision of a local evidentiary hearing is adverse to the applicant or beneficiary, the agency must --

* * * * *

(b) Inform the applicant or beneficiary that he or she has a right to appeal the decision to the State agency, in writing, within 10 days after the individual receives the notice of the adverse decision. The date on which the notice is received is considered to be 5 days after the date on the notice, unless the individual shows that he or she received the notice at a later date; and

* * * * *

19. Section 431.240 is amended by adding paragraph (c) to read as follows.

§431.240 Conducting the hearing.

* * * * *

(c) A hearing officer must have access to agency information necessary to issue a proper hearing decision, including information concerning State policies and regulations.

20. Section 431.241 is amended by revising paragraphs (a) and (b) to read as follows:

§431.241 Matters to be considered at the hearing.

* * * * *

(a) An Agency denial of, or action affecting, a claim for eligibility or services, or failure to act with reasonable promptness on such claim, including:

(1) An initial and subsequent decision regarding eligibility;

(2) A determination of the amount of medical expenses which must be incurred to establish income eligibility in accordance with §435.121(e)(4) or §435.821 of this part; or

(3) A determination of income for the purposes of imposing any premiums, enrollment fees, deductibles, copayments, coinsurance or other cost sharing under subpart A of part 447 of this subchapter.

(b) An Agency decision regarding changes in the type or level of benefits and services;

* * * * *

21. Section 431.242 is amended by --

A. Revising paragraph (a)(1).

B. Adding paragraph (f).

The revisions and additions read as follows:

§431.242 Procedural rights of the applicant or beneficiary.

* * * * *

(a) * * *

(1) The content of the applicant's or beneficiary's case file and electronic account, as defined in §435.4 of this part; and

* * * * *

(f) Request an expedited hearing, if appropriate.

22. Section 431.244 is amended by--

A. Revising paragraph (f)(1)(ii).

B. Redesignating paragraphs (f)(2) and (f)(3) as paragraphs (f)(4) and (f)(5), respectively.

C. Adding new paragraphs (f)(2) and (f)(3).

The revisions and additions read as follows:

§431.244 Hearing decisions.

* * * * *

(f) * * *

(1) * * *

(ii) The date the applicant, beneficiary, or enrollee (in a State that permits an MCO or PIHP enrollee direct access to a State fair hearing) requests a State fair hearing.

(2) Within 45 days from the date of the appeal decision issued by the Exchange appeals entity if –

(i) The individual's appeal to the Exchange appeals entity of a determination of eligibility for advanced payments of the premium tax credit or cost-sharing reductions is treated as a request for a fair hearing in accordance with §431.221(e) of this part, or the individual otherwise has both requested a fair hearing of an adverse Medicaid determination and appealed a determination of eligibility for advance payment of the premium tax credit or cost-sharing reductions; and

(ii) The Exchange appeals entity is not conducting the fair hearing for the individual, in accordance with §431.10(c)(1)(ii) of this part.

(3) As expeditiously as the individual's health condition requires, but no later than 3 working days after the agency receives a request from an individual or provider for an expedited hearing under §431.221 of this subpart, unless the agency determines that the request does not meet the criteria for expedited appeals and notifies the individual of such determination in accordance with §431.224(b)(2) of this part; or

* * * * *

PART 433--STATE FISCAL ADMINISTRATION

23. The authority citation for part 433 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

24. Section 433.138 is amended by revising paragraphs (d)(1) introductory text, (d)(3), (f), and (g)(1)(i) to read as follows:

§433.138 Identifying liable third parties.

* * * * *

(d) * * *

(1) Except as specified in paragraph (d)(2) of this section, as part of the data exchange requirements under §435.945 of this chapter, from the State wage information collection agency (SWICA) defined in §435.4 of this chapter and from the SSA wage and earnings files data as specified in §435.948(a)(1) of this chapter, the agency must—

* * * * *

(3) The agency must request, as required under §435.948(a)(2), from the State title IV-A agency, information not previously reported that identifies those Medicaid beneficiaries that are employed and their employer(s).

* * * * *

(f) Data exchanges and trauma code edits*:* Frequency. Except as provided in paragraph (l) of this section, the agency must conduct the data exchanges required in paragraphs (d)(1) and (d)(3) of this section, and diagnosis and trauma edits required in paragraphs (d)(4) and (e) of this section on a routine and timely basis. The State plan must specify the frequency of these activities.

(g) * * *

(1) * * *

(i) Within 45 days, the agency must follow up (if appropriate) on such information in order to identify legally liable third party resources and incorporate such information into the eligibility case file and into its third party data base and third party recovery unit so the agency

may process claims under the third party liability payment procedures specified in §433.139 (b) through (f); and

* * * * *

25. Section §433.145 is amended by revising paragraph (a)(2) to read as follows:

§ 433.145 Assignment of rights to benefits—State plan requirements.

(a) * * *

(2) Cooperate with the agency in establishing paternity and in obtaining medical support and payments, unless the individual establishes good cause for not cooperating, and except for individuals described in §435.116 (pregnant women), who are exempt from cooperating in establishing paternity and obtaining medical support and payments from, or derived from, the father of the child born out of wedlock; and

* * * * *

26. Section §433.147 is amended by--

A. Revising paragraph (a)(1), paragraph (c) introductory text, and paragraph (c)(1).

B. Removing paragraph (d).

The revisions read as follows:

§433.147 Cooperation in establishing paternity and in obtaining medical support and payments and in identifying and providing information to assist in pursuing third parties who may be liable to pay.

(a) * * *

(1) Except as exempt under §433.145(a)(2), establishing paternity of a child born out of wedlock and obtaining medical support and payments for himself or herself and any other person for whom the individual can legally assign rights; and

* * * * *

(c) Waiver of cooperation for good cause. (1) With respect to establishing paternity of a child born out of wedlock or obtaining medical care support and payments, or identifying or providing information to assist the State in pursuing any liable third party for a child for whom the individual can legally assign rights, the agency must find the cooperation is against the best interests of the child.

* * * * *

27. Section 433.148 is amended by revising paragraph (a)(2) to read as follows:

§ 433.148 Denial or termination of eligibility.

* * * * *

(a) * * *

(2) In the case of an applicant, does not attest to willingness to cooperate, and in the case of a beneficiary, refuses to cooperate in establishing paternity, obtaining medical child support and pursuing liable third parties, as required under §433.147(a) of this part unless cooperation has been waived;

* * * * *

28. Section 433.152 is amended by revising paragraph (b) to read as follows:

§433.152 Requirements for cooperative agreements for third party collections.

* * * * *

(b) Agreements with title IV-D agencies must specify that the Medicaid agency will provide reimbursement to the IV-D agency only for those child support services performed that are not reimbursable by the Office of Child Support Enforcement under title IV-D of the Act and that are necessary for the collection of amounts for the Medicaid program.

PART 435--ELIGIBILITY IN THE STATES, DISTRICT OF COLUMBIA, THE NORTHERN MARIANA ISLANDS, AND AMERICAN SAMOA

29. The authority citation for part 435 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

30. Section 435.3 is amended by –

A. In paragraph (a), adding section 1902(a)(46)(B), 1902(ee) and 1905(a) in numerical order.

B. Revising section 1903(v).

The revisions and additions read as follows:

§435.3 Basis.

(a) * * *

1902(a)(46)(B) Requirement to verify citizenship.

* * * * *

1902(ee) Option to verify citizenship through electronic data sharing with the Social Security Administration.

* * * * *

1903(v) Optional coverage of lawfully residing children and pregnant women in Medicaid and payment for emergency services under Medicaid provided to certain non-citizens.

* * * * *

1905(a) (third sentence; text below paragraph (29) Payment of other insurance premiums for medical or any other type of remedial care.

* * * * *

31. Section 435.4 is amended by—

A. Revising the definition of "Electronic account"

B. Adding the definitions of "Citizenship," "Combined eligibility notice," "Coordinated content," "Lawfully present," "Non-citizen," and "Qualified non-citizen" in alphabetical order.

The revision and additions read as follows:

§435.4 Definitions and use of terms.

* * * * *

Citizenship includes status as a "national of the United States" defined in 8 U.S.C. 1101(a)(22) that includes both citizens of the United States and non-citizen nationals of the United States.

Combined eligibility notice means an eligibility notice that informs an individual, or multiple family members of a household when feasible, of eligibility for each of the insurance affordability programs and enrollment in a qualified health plan through the Exchange, for which a determination or denial was made. A combined eligibility notice shall be issued by the last agency to make a determination of eligibility, regardless of which entity received the application. A combined notice must meet the requirements of §435.917(a) of this part and contain the content described in §435.917(b) and (c) of this part, except that information described in §435.917(b)(1)(iii)(D) of this part must be included in a combined notice issued by another insurance affordability program only if known to that program.

Coordinated content means information included in an eligibility notice regarding the transfer of the individual's or households' electronic account to another insurance affordability program for a determination of eligibility.

* * * * *

Electronic account means an electronic file that includes all information collected and generated by the agency regarding each individual's Medicaid eligibility and enrollment, including all documentation required under §435.914 of this part and including any information collected or generated as part of a fair hearing process conducted under subpart E of this chapter or through the Exchange appeals process conducted under 45 CFR part 155, Subpart F.

* * * * *

Lawfully present means an individual who is a non-citizen and who --

(1) Is a qualified non-citizen, as defined in this section;

(2) Is in a valid nonimmigrant status, as defined in 8 U.S.C. 1101(a)(15) or otherwise under the immigration laws (as defined in 8 U.S.C. 1101(a)(17));

(3) Is paroled into the United States in accordance with 8 U.S.C. 1182(d)(5) for less than 1 year, except for an individual paroled for prosecution, for deferred inspection or pending removal proceedings;

(4) Belongs to one of the following classes:

(i) Granted temporary resident status in accordance with 8 U.S.C. 1160 or 1255a, respectively;

(ii) Granted Temporary Protected Status (TPS) in accordance with 8 U.S.C. 1254a, and individuals with pending applications for TPS who have been granted employment authorization;

(iii) Granted employment authorization under 8 CFR 274a.12(c);

(iv) Family Unity beneficiaries in accordance with section 301 of Pub. L. 101-649, as amended;

(v) Under Deferred Enforced Departure (DED) in accordance with a decision made by the President;

(vi) Granted Deferred Action status;

(vii) Granted an administrative stay of removal under 8 CFR part 241;

(viii) Beneficiary of approved visa petition who has a pending application for adjustment of status;

(5) Is an individual with a pending application for asylum under 8 U.S.C. 1158, or for withholding of removal under 8 U.S.C. 1231, or under the Convention Against Torture who --

(i) Has been granted employment authorization; or

(ii) Is under the age of 14 and has had an application pending for at least 180 days;

(6) Has been granted withholding of removal under the Convention Against Torture;

(7) Is a child who has a pending application for Special Immigrant Juvenile status as described in 8 U.S.C. 1101(a)(27)(J);

(8) Is lawfully present in American Samoa under the immigration laws of American Samoa;

(9) Is a victim of a severe form of trafficking in persons, in accordance with the Victims of Trafficking and Violence Protection Act of 2000, Pub. L. 106-386, as amended (22 U.S.C. 7105(b)); or

(10) Exception. An individual with deferred action under the Department of Homeland Security's deferred action for childhood arrivals process, as described in the Secretary of Homeland Security's June 15, 2012 memorandum, shall not be considered to be lawfully present with respect to any of the above categories in paragraphs (1) through (9) of this definition.

* * * * *

Non-citizen has the same meaning as the term "alien," as defined in section 101(a)(3) of the Immigration and Nationality Act (INA), (8 U.S.C. 1101(a)(3)) and includes any individual who is not a citizen or national of the United States, defined at 8 U.S.C. 1101(a)(22).

* * * * *

Qualified non-citizen has the same meaning as the term "qualified alien" as defined at 8 U.S.C. § 1641(b) and (c).

* * * * *

32. Section 435.110 is amended by—

A. Republishing paragraph (c) introductory text.

B. Revising paragraph (c)(1).

The revisions read as follows:

§435.110 Parents and other caretaker relatives.

* * * * *

(c) Income standard. The agency must establish in its State plan the income standard as follows:

(1) The minimum income standard is a State's AFDC income standard in effect as of May 1, 1988 for the applicable family size converted to a MAGI-equivalent standard in accordance with guidance issued by the Secretary under section 1902(e)(14)(A) and (E) of the Act.

* * * * *

33. Section 435.112 is revised to read as follows:

§435.112 Families with Medicaid eligibility extended because of increased earnings or hours of employment.

(a) Basis and scope. (1) This section implements sections 408(a)(11)(A), 1902(e)(1)(A), and 1931(c)(2) of the Act.

(2) If Transitional Medical Assistance under section 1925 of the Act is not available or applicable, extended eligibility must be provided in accordance with this section, if applicable.

(b) Eligibility. (1) The extended eligibility period is for 4 months.

(2) The agency must provide coverage during an extended eligibility period to --

(i) A pregnant woman who was eligible and enrolled for Medicaid under §435.116 of this part with household income at or below the income limit described in paragraph (c) of this section in at least 3 out of the 6 months immediately preceding the month that eligibility under such section was lost due to increased earnings; and

(ii) A parent or other caretaker relative who was eligible and enrolled for Medicaid under §435.110 of this part, and any dependent child of such parent or other caretaker relative

who was eligible and enrolled under §435.118 of this part, in at least 3 out of the 6 months immediately preceding the month that eligibility for the parent or other caretaker relative under §435.110 of this part is lost due to—

(A) Increased earnings; or

(B) Increased hours from a parent's employment resulting in the parent no longer having a "dependent child," as defined at §435.4 of this part, living in his or her home.

(c) Income limit for potential extended eligibility is a State's income standard for coverage of parents and other caretaker relatives under §435.110(c) of this part.

§435.113 [Removed]

34. Section 435.113 is removed.

§435.114 [Removed.]

35. Section 435.114 is removed.

36. Section 435.115 is revised to read as follows:

§435.115 Families with Medicaid eligibility extended because of increased collection of spousal support.

(a) Basis. This section implements sections 408(a)(11)(B) and 1931(c)(1) of the Act.

(b) Eligibility. (1) The extended eligibility period is for 4 months.

(2) The agency must provide coverage during an extended eligibility period to --

(i) A pregnant woman who was eligible and enrolled for Medicaid under §435.116 of this part with household income at or below the income limit described in paragraph (c) of this section in at least 3 out of the 6 months immediately preceding the month that eligibility under such section was lost due to increased income from collection of spousal support under title IV-D of the Act; and

(ii) A parent or other caretaker relative who was eligible and enrolled for Medicaid under §435.110 of this part, and any dependent child of such parent or other caretaker relative

who was eligible and enrolled under §435.118 of this part, in at least 3 out of the 6 months immediately preceding the month that eligibility for the parent or other caretaker relative under §435.110 of this part is lost due to increased collection of spousal support under title IV-D of the Act.

(c) Income limit for potential extended eligibility is a State's income standard for coverage of parents and other caretaker relatives under §435.110(c) of this part.

37. Section 435.116 is amended by—

A. Republishing paragraph (d)(4) introductory text.

B. Revising paragraph (d)(4)(i).

The revisions read as follows:

§435.116 Pregnant women.

* * * * *

(d) * * *

(4) Applicable income limit for full Medicaid coverage of pregnant women. For purposes of paragraph (d)(1) of this section--

(i) The minimum applicable income limit is the State's AFDC income standard in effect as of May 1, 1988 for the applicable family size converted to a MAGI-equivalent standard in accordance with guidance issued by the Secretary under section 1902(e)(14)(A) and (E) of the Act.

* * * * *

38. Section 435.117 is revised to read as follows:

§435.117 Deemed newborn children.

(a) Basis. This section implements sections 1902(e)(4) and 2112(e) of the Act.

(b) Eligibility. (1) The agency must provide Medicaid to children from birth until the

child's first birthday without application if, for the date of the child's birth, the child's mother was eligible for and received covered services under--

(i) The Medicaid State plan (including during a period of eligibility under §435.914) regardless of whether payment for services for the mother is limited to services necessary to treat an emergency medical condition, as defined in section 1903(v)(3) of the Act;

(ii) The State's separate CHIP State plan as a targeted low-income pregnant woman in accordance with section 2112 of the Act, with household income at or below the income standard established by the agency under §435.118 of this part for infants under age 1;

(iii) At State option, the State's separate CHIP State plan as a targeted low-income child with household income at or below the income standard established by the agency under §435.118 for infants under age 1; or

(iv) At State option, the State's demonstration under section 1115 of the Act as a Medicaid or CHIP population, with household income at or below the income standard established by the agency under §435.118 for infants under age 1.

(2) The child is deemed to have applied and been determined eligible under the Medicaid State plan effective as of the date of birth, and remains eligible regardless of changes in circumstances (except if the child dies or ceases to be a resident of the State or the child's representative requests a voluntary termination of the child's eligibility) until the child's first birthday.

(c) At State option, the agency may provide deemed newborn eligibility under this section to a child if the child's mother was eligible for and receiving Medicaid in another State for the date of the child's birth.

(d) Medicaid identification number. (1) The Medicaid identification number of the mother serves as the child's identification number, and all claims for covered services provided to the child may be submitted and paid under such number, unless and until the State issues the

child a separate identification number in accordance with paragraph (d)(2) of this section.

(2) The State must issue a separate Medicaid identification number for the child prior to the effective date of any termination of the mother's eligibility or prior to the date of the child's first birthday, whichever is sooner, unless the child is determined to be ineligible (such as, because the child is not a State resident), except that the State must issue a separate Medicaid identification number for the child promptly after the agency is notified of a child under 1 year of age, residing in the State and born to a mother:

(i) Whose coverage is limited to services necessary for the treatment of an emergency medical condition, consistent with §435.139 or §435.350 of this part;

(ii) Covered under the State's separate CHIP; or

(iii) Who received Medicaid in another State on the date of birth.

39. Section 435.145 is revised to read as follows:

§435.145 Children with adoption assistance, foster care, or guardianship care under title IV-E.

(a) Basis. This section implements sections 1902(a)(10)(A)(i)(I) and 473(b)(3) of the Act.

(b) Eligibility. The agency must provide Medicaid to individuals for whom --

(1) An adoption assistance agreement is in effect with a State or tribe under title IV-E of the Act, regardless of whether adoption assistance is being provided or an interlocutory or other judicial decree of adoption has been issued; or

(2) Foster care or kinship guardianship assistance maintenance payments are being made by a State or Tribe under title IV-E of the Act.

40. Section 435.150 is added to read as follows:

§435.150 Former foster care children.

(a) Basis. This section implements section 1902(a)(10)(A)(i)(IX) of the Act.

(b) Eligibility. The agency must provide Medicaid to individuals who:

(1) Are under age 26;

(2) Are not eligible and enrolled for mandatory coverage under §§435.110 through 435.118 or §§435.120 through 435.145 of this part; and

(3) Were in foster care under the responsibility of the State or Tribe and enrolled in Medicaid under the State's Medicaid State plan or 1115 demonstration (or at State option were in foster care and Medicaid in any State) upon attaining:

(i) Age 18; or

(ii) Such higher age at which the State's or Tribe's foster care assistance ends under title IV-E of the Act.

41. Section 435.170 is revised to read as follows:

§435.170 Pregnant women eligible for extended or continuous eligibility.

(a) Basis. This section implements sections 1902(e)(5) and 1902(e)(6) of the Act.

(b) Extended eligibility for pregnant women. For a pregnant woman who was eligible and enrolled under subpart B, C, or D of this part on the date her pregnancy ends, the agency must provide coverage for pregnancy-related services in accordance with §435.116(d)(3) of this part through the last day of the month in which the 60-day post-partum period ends.

(c) Continuous eligibility for pregnant women. For a pregnant woman who was eligible and enrolled under subpart B, C, or D of this part and who, because of a change in household income, would not otherwise remain eligible, the agency must provide coverage for pregnancy-related services in accordance with §435.116(d)(3) of this part through the last day of the month in which the 60-day post-partum period ends.

(d) This section does not apply to—

(1) Pregnant women covered during a presumptive eligibility period under section 1920 of the Act.

(2) [Reserved]

42. Section 435.172 is added to read as follows:

§435.172 Continuous eligibility for hospitalized children.

(a) Basis. This section implements section 1902(e)(7) of the Act.

(b) The agency must provide Medicaid to a child eligible and enrolled under §435.118 until the end of an inpatient stay for which inpatient services are furnished, if the child:

(1) Was receiving inpatient services covered by Medicaid on the date the child is no longer eligible under §435.118 of this part based on the child's age or household income; and

(2) Would remain eligible but for attaining such age.

43. Section 435.201 is amended by--

A. Revising paragraph (a) introductory text and paragraph (a)(5).

B. Removing paragraph (a)(6).

The revisions read as follows:

§435.201 Individuals included in optional groups.

(a) The agency may choose to cover an optional group or groups of individuals who are not eligible and enrolled for mandatory coverage under the State's Medicaid State plan in accordance with subpart B of this part and who meet the appropriate eligibility criteria for groups specified in the separate sections of this subpart:

* * * * *

(5) Parents and other caretaker relatives (as defined in §435.4 of this part).

* * * * *

44. The undesignated center heading immediately preceding §435.210 is revised to read

as follows:

Options for Coverage of Families, Children, Adults, and the Aged, Blind, or Disabled

45. Section 435.210 is revised to read as follows:

§435.210 Optional eligibility for individuals who meet the income and resource requirements of the cash assistance programs.

(a) Basis. This section implements section 1902(a)(10)(A)(ii)(I) of the Act.

(b) Eligibility. The agency may provide Medicaid to any group or groups of individuals specified in §435.201(a)(1) through (a)(3) of this part who meet the income and resource requirements of SSI or an optional State supplement program in States that provide Medicaid to optional State supplement recipients.

46. Section 435.211 is revised to read as follows:

§435.211 Optional eligibility for individuals who would be eligible for cash assistance if they were not in medical institutions.

(a) Basis. This section implements section 1902(a)(10)(A)(ii)(IV) of the Act.

(b) Eligibility. The agency may provide Medicaid to any group or groups of individuals specified in §435.201(a)(1) through (a)(3) of this part who are institutionalized in a title XIX reimbursable medical institution and who:

(1) Are ineligible for the SSI or an optional State supplement program in States that provide Medicaid to optional State supplement recipients, because of lower income standards used under the program to determine eligibility for institutionalized individuals; but

(2) Would be eligible for aid or assistance under SSI or an optional State supplement program (as specified in §435.232 or §435.234 of this part) if they were not institutionalized.

47. Section 435.213 is added to read as follows:

§435.213 Optional eligibility for individuals needing treatment for breast or cervical cancer.

(a) Basis. This section implements sections 1902(a)(10)(A)(ii)(XVIII) and 1902(aa) of the Act.

(b) Eligibility. The agency may provide Medicaid to individuals who -

(1) Are under age 65;

(2) Are not eligible and enrolled for mandatory coverage under the State's Medicaid State plan in accordance with subpart B of this part;

(3) Have been screened under the Centers for Disease Control and Prevention (CDC) breast and cervical cancer early detection program (BCCEDP), established in accordance with the requirements of section 1504 of the Public Health Service Act, and determined by such screen to need treatment for breast or cervical cancer; and

(4) Do not otherwise have creditable coverage, as defined in section 2704(c) of the Public Health Service Act, for treatment of their breast or cervical cancer, but creditable coverage is not considered to be available just because the individual may:

(i) Receive medical services provided by the Indian Health Service, a tribal organization, or an Urban Indian organization; or

(ii) Obtain health insurance coverage only after a waiting period of uninsurance.

(c) An individual is considered to need treatment for breast or cervical cancer if the screen determines that:

(1) Definitive treatment for breast or cervical cancer is needed, including a precancerous condition or early stage cancer, and which may include diagnostic services as necessary to determine the extent and proper course of treatment; and

(2) More than routine diagnostic services or monitoring services for a precancerous breast or cervical condition are needed.

48. Section 435.214 is added to read as follows:

§435.214 Eligibility for family planning services.

(a) Basis. This section implements section 1902(a)(10)(A)(ii)(XXI) and 1902(ii) and clause (XVI) in the matter following 1902(a)(10)(G) of the Act.

(b) Eligibility. The agency may provide Medicaid to individuals (male and female) who meet all of the following requirements:

(1) Are not pregnant.

(2) Meet the income eligibility requirements at paragraph (c) of this section.

(c) Income standard. (1) The income standard established in the State plan may not exceed the higher of the income standard for pregnant women in effect under –

(i) The Medicaid State plan in accordance with §435.116 of this part.

(ii) A Medicaid demonstration under section 1115 of the Act.

(iii) The CHIP State plan under section 2112 of the Act

(iv) A CHIP demonstration under section 1115 of the Act.

(2) The individual's household income is determined in accordance with §435.603 of this part. The agency must indicate in its state plan the options selected by it under paragraph (k) of that section.

(d) Covered services. Individuals eligible under this section are covered for family planning and family planning-related benefits as described in clause (XVI) of the matter following 1902(a)(10)(G) of the Act.

49. Section 435.215 is added to read as follows:

§435.215 Individuals infected with tuberculosis.

(a) Basis. This section implements sections 1902(a)(10)(A)(XII) and 1902(z)(1) of the Act.

(b) Eligibility. The agency may provide Medicaid to individuals who—

(1) Are infected with tuberculosis;

(2) Are not otherwise eligible for mandatory coverage under the State's Medicaid plan;

(3) Have household income that does not exceed the income standard established by the state in its State plan, which standard must not exceed the higher of –

(i) The maximum income standard applicable to disabled individuals for mandatory coverage under subpart B of this part; or

(ii) The effective income level for coverage of individuals infected with tuberculosis under the state plan in effect as of March 23, 2010 or December 31, 2013, if higher, converted, at State option, to a MAGI-equivalent standard in accordance with guidance issued by the Secretary under section 1902(e)(14)(A) and (E) of the Act ; and

(c) Individuals eligible under this section are covered for the following services related to the treatment of infection with tuberculosis:

(1) Prescribed drugs, described in §440.120 of this subchapter;

(2) Physician's services, described in §440.50 of this subchapter;

(3) Outpatient hospital and rural health clinic described in §440.20 of this subchapter, and Federally-qualified health center services;

(4) Laboratory and x-ray services (including services to confirm the presence of the infection), described in §440.30 of this subchapter;

(5) Clinic Services, described in §440.90 of this subchapter;

(6) Case management services defined in §440.169 of this subchapter; and

(7) Services other than room and board designated to encourage completion of regimens of prescribed drugs by outpatients including services to observe directly the intake of prescription drugs.

50. Section 435.220 is revised to read as follows:

§435.220 Optional eligibility for parents and other caretaker relatives.

(a) Basis. This section implements section 1902(a)(10)(A)(ii)(I) of the Act for optional eligibility of parents and other caretaker relatives.

(b) Eligibility. The agency may provide Medicaid to parents and other caretaker relatives defined in §435.4 of this part and, if living with such parent or other caretaker relative, his or her spouse, whose household income is at or below the income standard established by the agency in its State plan, in accordance with paragraph (c) of this section.

(c) Income standard. The income standard under this section –

(1) Must exceed the income standard established by the agency under §435.110(c) of this part; and

(2) May not exceed the higher of the State's AFDC payment standard in effect as of July 16, 1996, or the State's highest effective income level for optional eligibility of parents and other caretaker relatives in effect under the Medicaid State plan or demonstration program under section 1115 of the Act as of March 23, 2010 or December 31, 2013, if higher, converted to a MAGI-equivalent standard in accordance with guidance issued by the Secretary under section 1902(e)(14)(A) and (E) of the Act.

51. Section 435.222 is revised to read as follows:

§435.222 Optional eligibility for reasonable classifications of individuals under age 21.

(a) Basis. This section implements sections 1902(a)(10)(A)(ii)(I) and (IV) of the Act for optional eligibility of individuals under age 21.

(b) Eligibility. The agency may provide Medicaid to all – or to one or more reasonable classifications, as defined in the State plan, of – individuals under age 21 (or, at State option, under age 20, 19 or 18) who have household income at or below the income standard established by the agency in its State plan in accordance with paragraph (c) of this section.

(c) Income standard. The income standard established under this section may not exceed the higher of the State's AFDC payment standard in effect as of July 16, 1996 or the State's

highest effective income level, if any, for such individuals under the Medicaid State plan or a demonstration program under section 1115 of the Act as of March 23, 2010 or December 31, 2013, if higher, converted to a MAGI-equivalent standard in accordance with guidance issued by the Secretary under section 1902(e)(14)(A) and (E) of the Act.

§435.223 [Removed]

52. Section 435.223 is removed.

53. Section 435.226 is added to read as follows:

§435.226 Optional eligibility for independent foster care adolescents.

(a) Basis. This section implements section 1902(a)(10)(A)(ii)(XVII) of the Act.

(b) Eligibility. The agency may provide Medicaid to individuals under age 21 (or, at State option, under age 20 or 19) who were in foster care under the responsibility of a State or Tribe (or, at State or Tribe option, only with respect to whom assistance under title IV-E of the Act was being provided) on the individual's 18th birthday and have household income at or below the income standard established by the agency in its State plan in accordance with paragraph (c) of this section.

(c) Income standard. The income standard established under this section may not exceed the higher of the State's AFDC payment standard in effect as of July 16, 1996 or the State's highest effective income level, if any, for such individuals under the Medicaid State plan or a demonstration program under section 1115 of the Act as of March 23, 2010 or December 31, 2013, if higher, converted to a MAGI-equivalent standard in accordance with guidance issued by the Secretary under section 1902(e)(14)(A) and (E) of the Act.

54. Section 435.227 is revised to read as follows:

§435.227 Optional eligibility for individuals under age 21 who are under State adoption assistance agreements.

(a) Basis. This section implements section 1902(a)(10)(A)(ii)(VIII) of the Act.

(b) Eligibility. The agency may provide Medicaid to individuals under age 21 (or, at State option, under age 20, 19, or 18):

(1) For whom an adoption assistance agreement (other than an agreement under title IV-E of the Act) between a State and the adoptive parent or parents is in effect;

(2) Who the State agency which entered into the adoption agreement determined could not be placed for adoption without Medicaid coverage because the child has special needs for medical or rehabilitative care; and

(3) Who, prior to the adoption agreement being entered into –

(i) Were eligible under the Medicaid State plan; or

(ii) Had household income at or below the income standard established by the agency in its State plan in accordance with paragraph (c) of this section.

(c) Income standard. The income standard established under this section may not exceed the higher of the State's AFDC payment standard in effect as of July 16, 1996 or the State's highest effective income level, if any, for such individuals under the Medicaid State plan or a demonstration program under section 1115 of the Act as of March 23, 2010 or December 31, 2013, if higher, converted to a MAGI-equivalent standard in accordance with guidance issued by the Secretary under section 1902(e)(14)(A) and (E) of the Act.

(d) The agency may limit eligibility under this section to children with respect to whom the State and such other States as are identified in the State plan have entered into an adoption assistance agreement.

55. Section 435.229 is revised to read as follows:

§435.229 Optional targeted low-income children.

(a) Basis. This section implements section 1902(a)(10)(A)(ii)(XIV) of the Act.

(b) Eligibility. The agency may provide Medicaid to individuals under age 19, or at State option within a range of ages under age 19 established in the State plan, who meet the

definition of an optional targeted low-income child in §435.4 of this part and have household income at or below the income standard established by the agency in its State plan in accordance with paragraph (c) of this section.

(c) Income standard. The income standard established under this section may not exceed the higher of –

(1) 200 percent FPL;

(2) A percentage of the Federal poverty level which exceeds the State's Medicaid applicable income level, defined at §457.10 of this chapter, by no more than 50 percentage points; and

(3) The highest effective income level for such individuals under the Medicaid State plan or a demonstration program under section 1115 of the Act as of March 23, 2010 or December 31, 2013, if higher, converted to a MAGI-equivalent standard in accordance with guidance issued by the Secretary under section 1902(e)(14)(A) and (E) of the Act.

56. Section 435.301 is amended by --

A. Removing paragraph (b)(1)(iii).

B. Redesignating paragraph (b)(1)(iv) as paragraph (b)(1)(iii).

C. Republishing paragraph (b)(2) introductory text.

D. Revising paragraph (b)(2)(ii).

The revisions read as follows:

§435.301 General rules.

* * * * *

(b) * * *

(2) The agency may provide Medicaid to any of the following groups of individuals:

* * * * *

(ii) Parents and other caretaker relatives (§435.310 of this part).

* * * * *

57. Section 435.310 is amended by revising the section heading and paragraph (a) to read as follows:

§435.310 Medically needy coverage of parents and other caretaker relatives.

(a) If the agency provides Medicaid for the medically needy, it may provide Medicaid to parents and other caretaker relatives who meet:

(1) The definition of "caretaker relative" at §435.4 of the part, or are the spouse of a parent or caretaker relative; and

(2) The medically needy income and resource requirements at subpart I of this part.

* * * * *

§435.401 [Amended]

58. Section 435.401 is amended by removing and reserving paragraph (c)(1).

59. Section 435.406 is amended by--

A. Revising the section heading.

B. Revising paragraph (a) introductory text, and paragraphs (a)(1) introductory text, (a)(1)(i), (a)(1)(ii), (a)(1)(iii).

C. Removing paragraph (a)(1)(iv) and redesignating paragraph (a)(1)(v) as paragraph (a)(1)(iv).

D. Republishing newly redesignated paragraph (a)(1)(iv) introductory text.

E. Adding newly redesignated paragraph (a)(1)(iv)(E).

F. In paragraph (a)(2), removing the terms "alien" or "aliens" and adding in their place the terms, "non-citizen" or "non-citizens" respectively.

G. In paragraph (a)(2)(ii), removing the reference to paragraph "(b)" and adding in its place a reference to paragraph "(c)".

H. Adding a new paragraph (a)(3).

I. Revising paragraph (b).

J. Adding paragraph (c).

The revisions read as follows:

§435.406 Citizenship and non-citizen eligibility.

(a) The agency must provide Medicaid to otherwise eligible individuals who are--

(1) Citizens, provided that –

(i) The individual has declared that he or she is a citizen or national of the United States; and

(ii) The agency has verified such declaration in accordance with §435.956(a) of this part.

(iii) For purposes of the declaration and citizenship verification requirements discussed in paragraphs (a)(1)(i) and (a)(1)(ii) of this section, an individual includes applicants under a section 1115 demonstration (including a family planning demonstration project) for which a State receives Federal financial participation in its expenditures.

(iv) The following groups of individuals are exempt from the requirements in paragraph (a)(1)(ii) of this section:

* * * * *

(E) Newborns who are eligible for coverage under §435.117 or §457.360, and individuals who received medical assistance on such basis in any State on or after July 1, 2006.

* * * * *

(3) For purposes of paragraphs (a)(1) and (a)(2) of this section, the declaration of citizenship or immigration status may be provided by the individual, or an adult member of the individual's family or household, an authorized representative, or if the applicant is a minor or incapacitated, someone acting responsibly for the applicant provided that such individual attests to having a reasonable basis to make a declaration of such status.

(b) <u>State option to provide Medicaid to Lawfully Residing Non-Citizen Children or</u>

Pregnant Women.

(1) Basic Rule. The agency may provide Medicaid to all individuals under 21 and/or all pregnant women who are lawfully present, as defined in §435.4 of this part, and who otherwise meet the eligibility requirements under this part;

(2) 5-Year Waiting Period and Other Restrictions Do Not Apply. The following restrictions on the provision of Medicaid do not apply to lawfully present non-citizen individuals under age 21 or pregnant women in States electing to provide eligibility in accordance with this paragraph: 8 U.S.C. 1611(a) (relating to the limitation on payment services for individuals who are not qualified non-citizens, 8 U.S.C. 1612(b) (relating to state option to limit eligibility of certain Lawful Permanent Residents to those credited with 40 qualifying quarters of work or seven year limitation), and 8 U.S.C. 1613 (relating to the 5-year waiting period), as implemented at paragraph (a)(2) of this section; and 8 U.S.C. 1631 (relating to sponsor deeming).

(c) Non-citizens whom the agency elects to cover under paragraph (b)(1) of this section and non-citizens whose eligibility is not restricted, as described in paragraph (b)(2) of this section, are covered for the same benefits as citizens who are eligible under the same section of subpart B, C or D of this part under which the non-citizen is eligible. For all other non-citizens who otherwise meet the eligibility requirements in this part, provisions of sections 1903(v)(2) and 1903(v)(3) of the Act, implemented at §440.255 of this subchapter, apply,

60. Section 435.407 is revised to read as follows:

§435.407 Types of acceptable documentary evidence of citizenship.

(a) Stand-alone evidence of citizenship. The following must be accepted as satisfactory documentary evidence of citizenship:

(1) A U.S. passport, including a U.S. Passport Card issued by the Department of State, without regard to any expiration date as long as such passport or Card was issued without limitation.

(2) A Certificate of Naturalization.

(3) A Certificate of U.S. Citizenship.

(4) A valid State-issued driver's license if the State issuing the license requires proof of U.S. citizenship, or obtains and verifies a social security number from the applicant who is a citizen before issuing such license.

(5)(i) Documentary evidence issued by a Federally recognized Indian Tribe, as published in the **Federal Register** by the Bureau of Indian Affairs within the U.S. Department of the Interior, and including Tribes located in a State that has an international border, which –

(A) Identifies the Federally recognized Indian Tribe that issued the document;

(B) Identifies the individual by name; and

(C) Confirms the individual's membership, enrollment, or affiliation with the Tribe.

(ii) Documents described in paragraph (a)(5)(i) of this section include, but are not limited to:

(A) A Tribal enrollment card;

(B) A Certificate of Degree of Indian Blood;

(C) A Tribal census document;

(D) Documents on Tribal letterhead, issued under the signature of the appropriate Tribal official, that meet the requirements of paragraph (a)(5)(i) of this section.

(b) Evidence of citizenship. If an applicant does not provide documentary evidence from the list in paragraph (a) of this section, the following must be accepted as satisfactory evidence to establish citizenship if also accompanied by an identity document listed in paragraph (c) of this section--

(1) A U.S. public birth certificate showing birth in one of the 50 States, the District of Columbia, Puerto Rico (if born on or after January 13, 1941), Guam, the Virgin Islands of the U.S. (on or after January 17, 1917), American Samoa, Swain's Island, or the Commonwealth of

the Northern Mariana Islands (CNMI) (after November 4, 1986 (CNMI local time)). The birth record document may be issued by the State, Commonwealth, Territory, or local jurisdiction. If the document shows the individual was born in Puerto Rico, the Virgin Islands of the U.S., or the CNMI before these areas became part of the U.S., the individual may be a collectively naturalized citizen.

(2) At State option, a cross match with a State vital statistics agency documenting a record of birth.

(3) A Certification of Report of Birth, issued to U.S. citizens who were born outside the U.S.

(4) A Report of Birth Abroad of a U.S. Citizen.

(5) A Certification of birth.

(6) A U.S. Citizen I.D. card.

(7) A Northern Marianas Identification Card, issued to a collectively naturalized citizen, who was born in the CNMI before November 4, 1986.

(8) A final adoption decree showing the child's name and U.S. place of birth, or if an adoption is not final, a Statement from a State-approved adoption agency that shows the child's name and U.S. place of birth.

(9) Evidence of U.S. Civil Service employment before June 1, 1976.

(10) U.S. Military Record showing a U.S. place of birth.

(11) A data match with the Systematic Alien Verification for Entitlements (SAVE) Program or any other process established by the Department of Homeland Security to verify that an individual is a citizen.

(12) Documentation that a child meets the requirements of section 101 of the Child Citizenship Act of 2000 (8 U.S.C. 1431).

(13) Medical records, including, but not limited to, hospital, clinic, or doctor records or admission papers from a nursing facility, skilled care facility, or other institution that indicate a U.S. place of birth.

(14) Life, health, or other insurance record that indicates a U.S. place of birth.

(15) Official religious record recorded in the U.S. showing that the birth occurred in the U.S

(16) School records, including pre-school, Head Start and daycare, showing the child's name and U.S. place of birth.

(17) Federal or State census record showing U.S. citizenship or a U.S. place of birth.

(18) If the applicant does not have one of the documents listed in paragraphs (a) or (b)(1) through (17) of this section, he or she may submit an affidavit signed by another individual under penalty of perjury who can reasonably attest to the applicant's citizenship, and that contains the applicant's name, date of birth, and place of U.S. birth. The affidavit does not have to be notarized.

(c) Evidence of identity. (1) The agency must accept the following as proof of identity, provided such document has a photograph or other identifying information including, but not limited to, name, age, sex, race, height, weight, eye color, or address:

(i) Identity documents listed at 8 CFR 274a.2 (b)(1)(v)(B)(1), except a driver's license issued by a Canadian government authority.

(ii) Driver's license issued by a State or Territory.

(iii) School identification card.

(iv) U.S. military card or draft record.

(v) Identification card issued by the Federal, State, or local government.

(vi) Military dependent's identification card.

(vii) U.S. Coast Guard Merchant Mariner card.

(2) For children under age 19, a clinic, doctor, hospital, or school record, including preschool or day care records.

(3) Two documents containing consistent information that corroborates an applicant's identity. Such documents include, but are not limited to, employer identification cards, high school and college diplomas (including high school equivalency diplomas), marriage certificates, divorce decrees, and property deeds or titles.

(4) Finding of identity from a Federal or State governmental agency. The agency may accept as proof of identity –

(i) A finding of identity from a Federal agency or another State agency, including but not limited to a public assistance, law enforcement, internal revenue or tax bureau, or corrections agency, if the agency has verified and certified the identity of the individual.

(ii) [Reserved]

(5) A finding of identity from an Express Lane agency, as defined in section 1902(e)(13)(F) of the Act.

(6) If the applicant does not have any document specified in paragraphs (c)(1) through (c)(3) of this section and identity is not verified under paragraph (c)(4) or (c)(5) of this section, the applicant may submit an affidavit signed, under penalty of perjury, by another person who can reasonably attest to the applicant's identity. Such affidavit must contain the applicant's name and other identifying information establishing identity, as describe in paragraph (c)(1) of this section. The affidavit does not have to be notarized.

(d) <u>Verification of citizenship by a Federal agency or another State</u>. (1) The agency may rely, without further documentation of citizenship or identity, on a verification of citizenship made by a Federal agency or another State agency, if such verification was done on or after July 1, 2006.

(2) [Reserved]

(e) Assistance with obtaining documentation. States must provide assistance to individuals who need assistance in securing satisfactory documentary evidence of citizenship in a timely manner.

(f) Documentary evidence. A photocopy, facsimile, scanned or other copy of a document must be accepted to the same extent as an original document under this section, unless information on the submitted document is inconsistent with other information available to the agency or the agency otherwise has reason to question the validity of the document or the information on the document.

§435.510 [Removed]

61. Remove §435.510 and the undesignated center heading of "Dependency."

§435.522 [Removed]

62. Remove §435.522 and the undesignated center heading of "Age."

63. Section 435.601 is amended by--

A. Revising paragraph (b).

B. Removing paragraphs (d)(1)(i) and (d)(1)(ii).

C. Redesignating paragraphs (d)(1)(iii) through (d)(1)(vi) as paragraphs (d)(1)(i) through (d)(1)(iv), respectively.

The revision reads as follows:

§435.601 Application of financial eligibility methodologies.

* * * * *

(b) Basic rule for use of cash assistance methodologies. (1) This section only applies to individuals excepted from application of MAGI-based methods in accordance with §435.603(j) of this subpart.

(2) Except as specified in paragraphs (c) and (d) of this section or in §435.121 of this part in determining financial eligibility of individuals as categorically or medically needy, the agency must apply the financial methodologies and requirements of the cash assistance program that is most closely categorically related to the individual's status.

* * * * *

64. Section 435.602 is amended by revising paragraph (a) to read as follows:

A.

B.

C.

The addition reads as follows:

§435.602 Financial responsibility of relatives and other individuals.

(a) Basic requirements. (1) This section only applies to individuals excepted from application of MAGI-based methods in accordance with §435.603(j) of this part.

(2) Subject to the provisions of paragraphs (b) and (c) of this section, in determining financial responsibility of relatives and other persons for individuals under Medicaid, the agency must apply the following requirements and methodologies:

(i) Except for a spouse of an individual or a parent for a child who is under age 21 or blind or disabled, the agency must not consider income and resources of any relative as available to an individual.

(ii) In relation to individuals under age 21 (as described in section 1905(a)(i) of the Act), the financial responsibility requirements and methodologies that apply include considering the income and resources of parents or spouses whose income and resources would be considered if the individual under age 21 were dependent under the State's approved AFDC plan, whether or not they are actually contributed, except as specified under paragraphs (c) and (d) of this section.

These requirements and methodologies must be applied in accordance with the provisions of the State's approved AFDC plan.

(iii) When a couple ceases to live together, the agency must count only the income of the individual spouse in determining his or her eligibility, beginning the first month following the month the couple ceases to live together.

(iv) In the case of eligible institutionalized spouses who are aged, blind, and disabled and who have shared the same room in a title XIX Medicaid institution, the agency has the option of considering these couples as eligible couples for purposes of counting income and resources or as eligible individuals, whichever is more advantageous to the couple.

* * * * *

65. Section 435.603 is amended by—

A. In paragraph (b), adding the definitions of "Child," "Parent," and "Sibling" in alphabetical order.

B. Adding paragraphs (d)(4) and (k).

C. Revising paragraphs (c), (d)(1), (f)(2)(i), (f)(3)(ii) and (iii), and (j)(4).

The revisions and additions read as follows:

§435.603 Application of modified adjusted gross income (MAGI).

* * * * *

(b) Definitions. For purposes of this section--

Child means a natural or biological, adopted or step child.

* * * * *

Parent means a natural or biological, adopted or step parent.

Sibling means natural or biological, adopted, half or step sibling.

* * * * *

(c) Basic rule. Except as specified in paragraph (i), (j) and (k) of this section, the agency must determine financial eligibility for Medicaid based on ‘‘household income’’ as defined in paragraph (d) of this section.

(d) * * *

(1) General rule. Except as provided in paragraphs (d)(2) through (d)(4) of this section, household income is the sum of the MAGI-based income, as defined in paragraph (e) of this section, of every individual included in the individual's household.

* * * * *

(4) In determining the eligibility of an individual for medical assistance under the eligibility group with the highest income standard under which the individual may be determined eligible using MAGI-based methodologies, an amount equivalent to 5 percentage points of the Federal poverty level for the applicable family size is deducted from household income.

* * * * *

(f) * * * * *

(2) * * * * *

(i) Individuals other than a spouse or child who expect to be claimed as a tax dependent by another taxpayer; and

* * * * *

(3) Rules for individuals who neither file a tax return nor are claimed as a tax dependent.

* * * * *

(ii) The individual’s children under the age specified in paragraph (f)(3)(iv) of this section; and

(iii) In the case of individuals under the age specified in paragraph (f)(3)(iv) of this section, the individual's parents and siblings under the age specified in paragraph (f)(3)(iv) of this section.

* * * * *

(j) * * *

(4) Individuals who request coverage for long-term care services and supports for the purpose of being evaluated for an eligibility group for which meeting a level-of-care need is a condition of eligibility or under which long-term care services not covered for individuals determined eligible using MAGI-based financial methods are covered. "Long-term care services" include nursing facility services, a level of care in any institution equivalent to nursing facility services; home and community-based services furnished under a waiver or State plan under sections 1915 or 1115 of the Act; home health services as described in sections 1905(a)(7) of the Act and personal care services described in sections 1905(a)(24) of the Act.

* * * * *

(k) In the case of an individual whose eligibility is being determined under §435.214 of this part, the agency may—

(1) Consider the household to consist of only the individual for purposes of paragraph (f) of this section.);

(2) Count only the MAGI-based income of the individual for purposes of paragraph (d) of this section.).

(3) Increase the family size of the individual, as defined in paragraph (b) of the section, by one.

66. Section 435.610 is amended by--

A. Revising paragraph (a) introductory text and paragraph (a)(2).

B. Removing paragraph (c).

The revisions a read as follows:

§ 435.610 Assignment of rights to benefits.

(a) Consistent with §433.145 through §433.148 of this chapter, as a condition of eligibility, the agency must require legally able applicants and beneficiaries to:

* * * * *

(2) In the case of applicants, attest that they will cooperate, and, in the case of beneficiaries, cooperate with the agency in –

(i) Establishing paternity and in obtaining medical support and payments, unless the individual establishes good cause for not cooperating or is a pregnant woman described §435.116; and

(ii) Identifying and providing information to assist the Medicaid agency in pursuing third parties who may be liable to pay for care and services under the plan, unless the individual establishes good cause for not cooperating.

* * * * *

67. Section 435.831 is amended by revising paragraph (b) introductory text, (b)(1), and (c) to read as follows:

§435.831 Income eligibility.

* * * * *

(b) Determining countable income. For purposes of determining medically needy eligibility under this part, the agency must determine an individual's countable income as follows:

(1) For individuals under age 21, pregnant women, and parents and other caretaker relatives, the agency may apply the AFDC methodologies in effect in the State as of August 16, 1996 or the MAGI-based methodologies defined in §435.603(e) of this part; except that, the

agency must comply with the terms of §435.602 of this part (relating to the financial responsibility of relatives and other individuals).

* * * * *

(c) Eligibility based on countable income. If countable income determined under paragraph (b) of this section is equal to or less than that applicable income standard under §435.814 of this part, the individual is eligible for Medicaid.

* * * * *

68. Section 435.905 is amended by-

A. Revising paragraph (b)(1).

B. Adding paragraph (b)(3).

The revisions and additions read as follows:

§435.905 Availability of program information.

* * * * *

(b) * * *

(1) Individuals who are limited English proficient through the provision of language services at no cost to the individual including, oral interpretation, written translations, and taglines in non-English languages indicating the availability of language services.

* * * * *

(3) Individuals must be informed of the availability of the services described in paragraph (b) of this section and how to access such services.

69. Section 435.907 is amended by adding paragraph (h) to read as follows.

§435.907 Application

* * * * *

(h) Reinstatement of withdrawn applications. (1) In the case of individuals described in paragraph (h)(2) of this section, the agency must reinstate the application submitted by the individual, effective as of the date the application was first received by the Exchange.

(2) Individuals described in this paragraph are individuals who –

(i) Submitted an application described in paragraph (b) of this section to the Exchange;

(ii) Withdrew their application for Medicaid in accordance with 45 CFR 155.302(b)(4)(A);

(iii) Are assessed as potentially eligible for Medicaid by the Exchange appeals entity.

70. Section 435.908 is amended by adding paragraph (c) to read as follows:

§435.908 Assistance with application and renewal.

* * * * *

(c) Certified Application Assisters. (1) At State option, the agency may certify staff and volunteers of State-designated organizations to act as application assisters, authorized to provide assistance to applicants and beneficiaries with the application process and during renewal of eligibility. To be certified, application assisters must be –

(i) Authorized and registered by the agency to provide assistance at application and renewal;

(ii) Effectively trained in the eligibility and benefits rules and regulations governing enrollment in a QHP through the Exchange and all insurance affordability programs operated in the State, as implemented in the State; and

(iii) Trained in and subject to regulations relating to the safeguarding and confidentiality of information and conflict of interest, including regulations set forth at part 431, subpart F of this chapter, and at 45 CFR 155.260(f), regulations relating to the prohibition against

reassignment of provider claims specified in §447.10 of this chapter, and all other State and Federal laws concerning conflicts of interest and confidentiality of information.

(2) For purposes of this section, assistance includes providing information on insurance affordability programs and coverage options, helping individuals complete an application or renewal, gathering required documentation, submitting applications and renewals to the agency, interacting with the agency on the status of such applications and renewals, assisting individuals with responding to any requests from the agency, and managing their case between the eligibility determination and regularly scheduled renewals. Application assisters may be certified by the agency to act on behalf of applicants and beneficiaries with respect to one, some or all of the permitted assistance activities.

(3) If the agency elects to certify application assisters, it must establish –

(i) A designated web portal to which only certified application assisters have access and through which the assisters may provide the assistance described in paragraph (c)(2) of this section. The agency must develop a secure mechanism to ensure that certified application assisters are able to perform only those activities for which they are certified.

(ii) Procedures to ensure that –

(A) Applicants and beneficiaries are informed of the functions and responsibilities of certified application assisters;

(B) Individuals are able to authorize application assisters to receive confidential information about the individual related to the individual's application for or renewal of Medicaid; and

(C) The agency does not disclose confidential applicant or beneficiary information to an application assister unless the applicant or beneficiary has authorized the application assister to receive such information.

(4) Application assisters may not impose any charge on applicants or beneficiaries for application assistance.

§435.909 [Amended]

71. Paragraph (a) is removed and reserved.

72. Section 435.910 is amended by revising paragraph (g) to read as follows:

§435.910 Use of social security number.

* * * * *

(g) The agency must verify the SSN furnished by an applicant or beneficiary with SSA to insure the SSN was issued to that individual, and to determine whether any other SSNs were issued to that individual.

* * * * *

73. Section §435.911 is amended by—

A. Revising paragraph (b)(1) introductory text, paragraph (b)(1)(i), paragraph (c) introductory text, and paragraph (c)(1).

B. Adding paragraph (b)(2).

The revisions and addition read as follows:

§435.911 Determination of eligibility.

* * * * *

(b)(1) Except as provided in paragraph (b)(2) of this section, applicable modified adjusted gross income standard means 133 percent of the Federal poverty level or, if higher –-

(i) In the case of parents and other caretaker relatives described in §435.110(b) of this part, the income standard established in accordance with §435.110(c) or §435.220(c) of this part;

* * * * *

(2) In the case of individuals who have attained at least age 65 and individuals who have attained at least age 19 and who are entitled to or enrolled for Medicare benefits under part A or

B or title XVIII of the Act, there is no applicable modified adjusted gross income standard, except that in the case of such individuals –

(i) Who are also pregnant, the applicable modified adjusted gross income standard is the standard established under paragraph (b)(1) of this section; and

(ii) Who are also a parent or caretaker relative, as described in §435.4 of this part, the applicable modified adjusted gross income standard is the higher of the income standard established in accordance with §435.110(c) or §435.220(c) of this part.

(c) For each individual who has submitted an application described in §435.907 or whose eligibility is being renewed in accordance with § 435.916 and who meets the non-financial requirements for eligibility (or for whom the agency is providing a reasonable opportunity to verify citizenship or immigration status in accordance with §435.956(g) of this part), the state Medicaid agency must comply with the following—

(1) The agency must, promptly and without undue delay consistent with timeliness standards established under §435.912, furnish Medicaid to each such individual whose household income is at or below the applicable modified adjusted gross income standard.

* * * * *

§ 435.913 [Removed]

74. Section 435.913 is removed.

75. Section §435.917 is added to read as follows.

§ 435.917 Notice of agency's decision concerning eligibility

(a) Notice of eligibility determinations. Consistent with §§431.206 through 431.214 of this chapter, the agency must provide all applicants and beneficiaries with timely and adequate written notice of any decision affecting their eligibility, including a denial, termination or suspension of eligibility, or a denial or change in benefits and services. Such notice must--

(1) Be written in plain language;

(2) Be accessible to persons who are limited English proficient and individuals with disabilities, consistent with §435.905(b) of this subpart, and

(3) If provided in electronic format, comply with §435.918 of this subpart.

(b) Content of eligibility notice.

(1) Notice of approved eligibility. Any notice of an approval of Medicaid eligibility must include, but is not limited to, the following information–

(i) The basis and effective date of eligibility;

(ii) The circumstances under which the individual must report, and procedures for reporting, any changes that may affect the individual's eligibility;

(iii) If applicable, the amount of medical expenses which must be incurred to establish eligibility in accordance with §435.121 or §435.831 of this part.

(iv) Information on the level of benefits and services approved, including, if applicable, the notice relating to any premiums, enrollment fees, and cost sharing required under Part 447 Subpart A of this chapter, and the right to appeal the level of benefits and services approved.

(2) Notice of adverse action including denial, termination or suspension of eligibility or change in benefits or services. Any notice of denial, termination or suspension of Medicaid eligibility or change in benefits or services must be consistent §431.210 of this chapter.

(c) Whenever an approval, denial, or termination of eligibility is based on an applicant's or beneficiary's having household income at or below the applicable modified adjusted gross income standard in accordance with §435.911 of this subpart, the eligibility notice must contain—

(1) Information regarding bases of eligibility other than the applicable modified adjusted gross income standard and the benefits and services afforded to individuals eligible on such other

bases, sufficient to enable the individual to make an informed choice as to whether to request a determination on such other bases; and

(2) Information on how to request a determination on such other bases;

(d) The agency's responsibility to provide notice under this section is satisfied by a combined eligibility notice, as defined in §435.4 of this chapter, provided by the Exchange or other insurance affordability program in accordance with an agreement between the agency and such program consummated in accordance with §435.1200(b)(3) of this chapter, except that, if the information described in paragraph (b)(1)(iii) through (iv) of this section is not included in such combined eligibility notice, the agency must provide the individual with a supplemental notice of such information, consistent with this section.

76. Section 435.918 is added to read as follows:

§ 435.918 Use of electronic notices.

(a) The agency must provide individuals with a choice to receive notices and information required under this part or subpart E of part 431 of this chapter in electronic format or by regular mail. If the individual elects to receive communications from the agency electronically, the agency must –

(1) Confirm by regular mail the individual's election to receive notices electronically;

(2) Inform the individual of his or her right to change such election, at any time, to receive notices through regular mail;

(3) Post notices to the individual's electronic account within 1 business day of notice generation;

(4) Send an email or other electronic communication alerting the individual that a notice has been posted to his or her account. The agency may not include confidential information in the email or electronic alert.

(5) If an electronic communication is undeliverable, send any notice by regular mail within three business days of the date of the failed electronic communication;

(6) At the individual's request, provides through regular mail any notice posted to the individual's electronic account.

(b) The agency may provide notice or other communications electronically only if the individual--

(1) Has affirmatively elected to receive electronic communications in accordance with paragraph (a) of this section; and

(2) Is permitted to change such election at any time.

§435.919 [Removed]

77. Section 435.919 is removed.

78. Section 435.923 is added to read as follows:

§435.923 Authorized Representatives.

(a) The agency must permit applicants and beneficiaries to designate an individual or organization to act responsibly on their behalf in assisting with the individual's application and renewal of eligibility and other ongoing communications with the agency. Such a designation must be in writing including the applicant's signature, and must be permitted at the time of application and at other times. Legal documentation of authority to act on behalf of an applicant or beneficiary under state law, such as a court order establishing legal guardianship or a power of attorney, shall serve in the place of written authorization by the applicant or beneficiary.

(b) Representatives may be authorized to –

(1) Sign an application on the applicant's behalf;

(2) Complete and submit a renewal form;

(3) Receive copies of the applicant or beneficiary's notices and other communications from the agency;

(4) Act on behalf of the applicant or beneficiary in all other matters with the agency.

(c) The power to act as an authorized representative is valid until the applicant or beneficiary modifies the authorization or notifies the agency that the representative is no longer authorized to act on his or her behalf, or the authorized representative informs the agency that he or she no longer is acting in such capacity, or there is a change in the legal authority upon which the individual or organization's authority was based. Such notice must be in writing and should include the applicant or authorized representative's signature as appropriate.

(d) The authorized representative –

(1) Is responsible for fulfilling all responsibilities encompassed within the scope of the authorized representation, as described in paragraph (b)(2) of this section, to the same extent as the individual he or she represents;

(2) Must agree to maintain, or be legally bound to maintain, the confidentiality of any information regarding the applicant or beneficiary provided by the agency.

(e) The agency must require that, as a condition of serving as an authorized representative, a provider or staff member or volunteer of an organization must sign an agreement that he or she will adhere to the regulations in part 431, subpart F of this chapter and at 45 CFR 155.260(f) (relating to confidentiality of information), §447.10 of this chapter (relating to the prohibition against reassignment of provider claims as appropriate for a health facility or an organization acting on the facility's behalf), as well as other relevant State and Federal laws concerning conflicts of interest and confidentiality of information.

(f) For purposes of this section, the agency must accept electronic, including telephonically recorded, signatures and handwritten signatures transmitted by facsimile or other electronic transmission. Designations of authorized representatives must be accepted through all of the modalities described in §435.907(a) of this part.

79. Section 435.926 is added to read as follows:

§435.926 Continuous eligibility for children.

(a) Basis. This section implements section 1902(e)(12) of the Act.

(b) Eligibility. The agency may provide continuous eligibility for the length of a continuous eligibility period specified in paragraph (c) of this section for an individual who is:

(1) Under age 19 or under a younger age specified by the agency in its State plan; and

(2) Eligible and enrolled for mandatory or optional coverage under the State plan in accordance with subpart B or C of this part.

(c) Continuous eligibility period. (1) The agency must specify in the State plan the length of the continuous eligibility period, not to exceed 12 months.

(2) A continuous eligibility period begins on the effective date of the individual's most recent determination or renewal of eligibility at the end of the length of the continuous eligibility period specified in the State plan.

(d) Applicability. A child's eligibility may not be terminated during a continuous eligibility period, regardless of any changes in circumstances, unless:

(1) The child attains the maximum age specified in accordance with paragraph (b)(1) of this section;

(2) The child or child's representative requests a voluntary termination of eligibility;

(3) The child ceases to be a resident of the State;

(4) The agency determines that eligibility was erroneously granted at the most recent determination or renewal of eligibility because of agency error or fraud, abuse, or perjury attributed to the child or the child's representative; or

(5) The child dies.

80. Section 435.940 is amended by revising the first sentence to read as follows:

§435.940 Basis and scope.

The income and eligibility verification requirements set forth at §435.940 through § 435.960 of this part are based on sections 1137, 1902(a)(4), 1902(a)(19), 1902(a)(46)(B), 1902(ee), 1903(r)(3), 1903(x), and 1943(b)(3) of the Act, and section 1413 of the Affordable Care Act. * * *

81. Section 435.952 is amended by adding paragraph (c)(3) to read as follows:

§435.952 Use of information and requests of additional information from individuals.

* * * * *

(c) * * *

(3) Exception for Special Circumstances: The agency must establish an exception to permit, on a case-by-case basis, self-attestation of individuals for all eligibility criteria when documentation does not exist at the time of application or is not reasonably available, such as for individuals who are homeless or have experienced domestic violence or a natural disaster. Except that this does not apply if documentation is specifically required under title XIX, such as is the case of verifying citizenship and immigration status, as implemented at §435.956(a) of this part.

* * * * *

82. Section 435.956 is amended by—

A. Adding paragraph (a).

B. Adding paragraph (g).

The revision and addition read as follows:

§435.956 Verification of other non-financial information.

(a) Citizens and Non-citizens. (1) The agency must verify citizenship and immigration status through the electronic service established in §435.949 if available. If the agency is unable to verify citizenship or immigration status through such service the agency must –

(i) Verify citizenship in accordance with section 1902(ee) of the Act or §435.407 of this part consistent with the requirements of §435.952(c)(2)(ii) of this part.

(ii) Verify immigration status in accordance with section 1137(d) of the Act and §435.406 of this part, consistent with the requirements of §435.952(c)(2)(ii) of this part.

(2) If the agency cannot promptly verify the citizenship or immigration status of an individual in accordance with paragraph (a)(1) of this section, the agency–

(i) Must comply with paragraph (g) of this section; and

(ii) May not delay, deny, reduce or terminate benefits for an individual who is otherwise eligible for Medicaid during the reasonable opportunity period described in paragraph (g) of this section, in accordance with §435.911(c) of this part.

(3) The agency must maintain a record of having verified citizenship or immigration status for each individual, in a case record or electronic database. The agency may not re-verify or require an individual to re-verify citizenship at a renewal of eligibility or subsequent application following a break in coverage.

* * * * *

(g) Reasonable opportunity period. (1) The agency must provide a reasonable opportunity period to individuals for whom the agency is unable to promptly verify citizenship or satisfactory immigration status in accordance with paragraph (a) of this section, as well as notice of such opportunity. Such notice must be accessible to persons who are limited English proficient and individuals with disabilities, consistent with §435.905(b) of this chapter. During such reasonable opportunity period, the agency must, if relevant to verification of the individual's status –

(i) Assist the individual in obtaining an SSN, in accordance with §435.910;

(ii) Attempt to resolve any inconsistencies, including typographical or other clerical errors, between information provided by the individual and data from an electronic data source, and resubmit corrected information to the electronic data source.

(iii) Provide the individual with information on how to contact the source of the electronic data so he or she can attempt to resolve such inconsistencies directly with such source; and

(iv) Permit the individual to provide other documentation of citizenship or immigration status, in accordance with section 1137(d) of the Act and §435.406 and §435.407 of this part.

(2) The reasonable opportunity period –

(i) Begins on, and must extend 90 days from, the date on which the notice described in paragraph (g)(1) of this section is received by the individual. The date on which the notice is received is considered to be 5 days after the date on the notice, unless the individual shows that he or she did not receive the notice within the 5-day period.

(ii) At state option, may be extended beyond 90 days if the individual is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation in accordance with paragraph (g)(1) of this section or the agency needs more time to complete the verification process.

(3) At State option, the agency may begin to furnish benefits to otherwise eligible individuals during the reasonable opportunity period under paragraph (a)(2)(ii) of this section on an earlier date, up to and including the date the notice is sent or the date of application containing the declaration of citizenship or immigration status by or on behalf of the individual.

(4) If, by the end of the reasonable opportunity period, the individual's citizenship or immigration status has not been verified in accordance with paragraph (a) of this section, the agency must take action within 30 days to terminate eligibility in accordance with part 431

subpart E (relating to notice and appeal rights), except that §431.230 and §431.231 of this part (relating to maintaining and reinstating services) may be applied at State option.

83. Section 435.1001 is amended by—

A. Republishing paragraph (a) introductory language.

B. Revising paragraph (a)(2).

The revisions read as follows:

§435.1001 FFP for administration.

(a) FFP is available in the necessary administrative costs the State incurs in--

* * * * *

(2) Administering presumptive eligibility.

* * * * *

84. Section 435.1002 is amended by—

A. Republishing paragraph (c) introductory language.

B. Revising paragraphs (c)(1) and (c)(4).

The revisions read as follows:

§435.1002 FFP for services.

* * * * *

(c) FFP is available in expenditures for services covered under the plan that are furnished—-

(1) During a presumptive eligibility period to individuals who are determined to be presumptively eligible for Medicaid in accordance with subpart L of this part;

* * * * *

(4) Regardless of whether such individuals file an application for a full eligibility determination or are determined eligible for Medicaid following the presumptive eligibility period.

85. Section 435.1004 is amended by revising paragraph (b) to read as follows:

§435.1004 Beneficiaries overcoming certain conditions of eligibility.

* * * * *

(b) FFP is available for a period not to exceed--

(1) The period during which a recipient of SSI or an optional State supplement continues to receive cash payments while these conditions are being overcome; or

(2) For beneficiaries, eligible for Medicaid only and recipients of SSI or an optional State supplement who do not continue to receive cash payments, the second month following the month in which the beneficiary's Medicaid coverage would have been terminated.

86. Section 435.1008 is revised to read as follows:

§435.1008 FFP in expenditures for medical assistance for individuals who have declared citizenship or nationality or satisfactory immigration status.

(a) This section implements sections 1137 and 1902(a)(46)(B)of the Act.

(b) Except as provided in paragraph (c) of this section, FFP is not available to a State for expenditures for medical assistance furnished to individuals unless the State has verified citizenship or immigration status in accordance with §435.956 of this part.

(c) FFP is available to States for otherwise eligible individuals whose declaration of U.S. citizenship or satisfactory immigration status in accordance with section 1137(d) of the Act and §435.406(a)(1)(i) of this part has been verified in accordance with §435.956, or for whom benefits are provided during a reasonable opportunity period to verify citizenship, nationality, or immigration status in accordance with section §435.956(a)(2) of this part.

FFP for Premium Assistance

87. Add a new undesignated center heading immediately following §435.1012 as set forth above.

88. Section 435.1015 is added to read as follows:

§435.1015 FFP for premium assistance for plans in the individual market.

(a) FFP is available for payment of the costs of insurance premiums for an individual health plan on behalf of an individual who is eligible for Medicaid under this part, subject to the following conditions:

(1) The insurer is obligated to pay primary to Medicaid for all health care items and services for which the insurer is legally and contractually responsible under the individual health plan, as required under part 433 subpart D of this chapter;

(2) The agency furnishes all benefits for which the individual is covered under the State plan that are not available through the individual health plan;

(3) The individual does not incur any cost sharing charges in excess of any amounts imposed by the agency under subpart A of part 447; and

(4) The cost of purchasing such coverage, including administrative expenditures and the costs of providing wraparound benefits for items and services covered under the Medicaid State plan, but not covered under the individual health plan, must be comparable to the cost of providing direct coverage under the State plan.

(b) A State may not require an individual who is eligible for services under the Medicaid State plan to enroll in premium assistance under this section as a condition of eligibility under this part.

Subpart L—Options for Coverage of Special Groups under Presumptive Eligibility

89. The heading for subpart L is revised as set forth above.

90. Section 435.1100 is revised to read as follows:

§435.1100 Basis for presumptive eligibility.

This subpart implements sections 1920, 1920A, 1920B, 1920C, and 1902(a)(47)(B) of the Act.

91. Remove the undesignated center heading “Presumptive Eligibility for Children” that

is immediately before §435.1101.

92. Section 435.1101 is amended by—

A. Removing the definition of "Application form."

C. Adding the definition of "Application."

D. Amending the definition of "Qualified entity" by redesignating paragraph (10) as paragraph (11), and adding a new paragraph (10).

The additions read as follows:

§435.1101 Definitions related to presumptive eligibility for children.

Application means, consistent with the definition at §435.4 of this part, the single streamlined application adopted by the agency under §435.907(a) of this part.

* * * * *

Qualified entity * * *

(10) Is a health facility operated by the Indian Health Service, a Tribe or Tribal organization under the Indian Self Determination and Education Assistance Act (25 U.S.C. 450 et seq.), or an Urban Indian Organization under title V of the Indian Health Care Improvement Act (25 U.S.C. 1651 et seq.).

* * * * *

93. Section 435.1102 is amended by—

A. Revising the section heading.

B. Revising paragraphs (a) and (b)(3).

C. Removing "and" at the end of paragraph (b)(2)(iv)(B) and adding "and" at the end of paragraph (b)(2)(v)(B);

D. Adding paragraphs (b)(2)(vi), (d) and (e).

E. Removing paragraph (b)(4).

The revisions and additions read as follows:

§435.1102 Children covered under presumptive eligibility.

(a) The agency may elect to provide Medicaid services for children under age 19 or a younger age specified by the State during a presumptive eligibility period following a determination by a qualified entity, on the basis of preliminary information, that the individual has gross income (or, at state option, a reasonable estimate of household income, as defined in §435.603 of this part, determined using simplified methods prescribed by the agency) at or below the income standard established by the State for the age of the child under §435.118(c) or under §435.229 if applicable and higher.

(b) * * *

(2) * * *

(vi) Do not delegate the authority to determine presumptive eligibility to another entity.

(3) Establish oversight mechanisms to ensure that presumptive eligibility determinations are being made consistent with the statute and regulations.

* * * * *

(d) The agency –

(1) May require, for purposes of making a presumptive eligibility determination under this section, that the individual has attested to being, or another person who attests to having reasonable knowledge of the individual's status has attested to the individual being, a –

(i) Citizen or national of the United States or in satisfactory immigration status; or

(ii) Resident of the State; and

(2) May not –

(i) Impose other conditions for presumptive eligibility not specified in this section; or

(ii) Require verification of the conditions for presumptive eligibility.

(e) Notice and fair hearing regulations in subpart E of part 431 of this chapter do not apply to determinations of presumptive eligibility under this section.

94. Section 435.1103 is added to read as follows:

§435.1103 Presumptive eligibility for other individuals.

(a) The terms of §435.1101 and §435.1102 of this subpart apply to pregnant women such that the agency may provide Medicaid to pregnant women during a presumptive eligibility period following a determination by a qualified entity that the pregnant woman has income at or below the income standard established by the State under §435.116(c), except that coverage of services provided to such women are limited to ambulatory prenatal care and the number of presumptive eligibility periods that may be authorized for pregnant women is one per pregnancy.

(b) If the agency provides Medicaid during a presumptive eligibility period to children under §435.1102 of this subpart or to pregnant women under paragraph (a) of this section, the agency may also apply the terms of §435.1101 and §435.1102 of this subpart to the individuals described in one or more of the following sections of this part, based on the income standard established by the state for such individuals and providing the benefits covered under that section: §§435.110 (parents and caretaker relatives), 435.119 (individuals aged 19 or older and under age 65), 435.150 (former foster care children), and 435.218 (individuals under age 65 with income above 133 percent FPL).

(c) (1) The terms of §435.1101 and §435.1102 of this subpart apply to individuals who may be eligible under §435.213 of this part (relating to individuals with breast or cervical cancer) or §435.214 of this part (relating to eligibility for limited family planning benefits) such that the agency may provide Medicaid during a presumptive eligibility period following a determination by a qualified entity described in paragraph (c)(2) of this section that–

(i) The individual meets the eligibility requirements of §435.213; or

(ii) The individual meets the eligibility requirements of §435.214, except that coverage provided during a presumptive eligibility period to such individuals is limited to the services described in §435.214(d).

(2) Qualified entities described in this paragraph include qualified entities which participate as a provider under the State plan and which the agency determines are capable of making presumptive eligibility determinations.

95. Section 435.1110 is added to read as follows:

§435.1110 Presumptive eligibility determined by hospitals.

(a) Basic rule. The agency must provide Medicaid during a presumptive eligibility period to individuals who are determined by a qualified hospital, on the basis of preliminary information, to be presumptively eligible in accordance with the policies and procedures established by the State consistent with this section and §§435.1102 and 435.1103 of this part, but regardless of whether the agency provides Medicaid during a presumptive eligibility period under such sections.

(b) Qualified hospitals. A qualified hospital is a hospital that –

(1) Participates as a provider under the State plan or a demonstration under section 1115 of the Act, notifies the agency of its election to make presumptive eligibility determinations under this section, and agrees to make presumptive eligibility determinations consistent with State policies and procedures;

(2) At State option, assists individuals in completing and submitting the full application and understanding any documentation requirements; and

(3) Has not been disqualified by the agency in accordance with paragraph (d) of this section.

(c) State options for bases of presumptive eligibility. The agency may –

(1) Limit the determinations of presumptive eligibility which hospitals may elect to make under this section to determinations based on income for children, pregnant women, parents and caretaker relatives, and other adults, consistent with §435.1102 and §435.1103 of this subpart; or

(2) Permit hospitals to elect to make presumptive eligibility determinations on additional bases under the State plan or an 1115 demonstration.

(d) Disqualification of hospitals. (1) The agency may establish standards for qualified hospitals related to the proportion of individuals determined presumptively eligible for Medicaid by the hospital who:

(i) Submit a regular application, as described in §435.907 of this part, before the end of the presumptive eligibility period; or

(ii) Are determined eligible for Medicaid by the agency based on such application.

(2) The agency must take action, including, but not limited to, disqualification of a hospital as a qualified hospital under this section, if the agency determines that the hospital is not –

(i) Making, or is not capable of making, presumptive eligibility determinations in accordance with applicable state policies and procedures; or

(ii) Meeting the standard or standards established by the agency under paragraph (d)(1) of this section.

96. Section 435.1200 is amended by --

A. Revising the section heading.

B. Revising paragraphs (a), (b), (c) introductory text, (c)(3), (d), and (e).

C. Adding paragraphs (g).

The revisions and additions read as follows.

§435.1200 Medicaid agency responsibilities for a coordinated eligibility and enrollment process with other insurance affordability programs.

(a) Statutory basis, purpose, and definitions. (1) Statutory basis and purpose. This section implements sections 1943(b)(3) and 2201(b)(3)(B) of the Affordable Care Act to ensure coordinated eligibility and enrollment among insurance affordability programs.

(2) Definitions.

(i) Combined eligibility notice has the meaning as provided in §435.4 of this part.

(ii) Coordinated content has the meaning as provided in §435.4 of this part.

(b) General requirements and definitions. The State Medicaid agency must--

(1) Fulfill the responsibilities set forth in paragraphs (d) through (g) and, if applicable, paragraph (c) of this section.

(2) Certify for the Exchange and other insurance affordability programs the criteria applied in determining Medicaid eligibility.

(3) Enter into and, upon request, provide to the Secretary one or more agreements with the Exchange, Exchange appeals entity and the agencies administering other insurance affordability programs as are necessary to fulfill the requirements of this section, including a clear delineation of the responsibilities of each program to –

(i) Minimize burden on individuals seeking to obtain or renew eligibility or to appeal a determination of eligibility for enrollment in a QHP or with respect to one or more insurance affordability program;

(ii) Ensure compliance with paragraphs (d) through (g) of this section and, if applicable, paragraph (c) of this section;

(iii) Ensure prompt determinations of eligibility and enrollment in the appropriate program without undue delay, consistent with timeliness standards established under § 435.912, based on the date the application is submitted to any insurance affordability program.

(iv) Provide for a combined eligibility notice to individuals, as well as multiple members of the same household applying on the same application to the maximum extent feasible, for enrollment in a QHP through the Exchange and all insurance affordability programs.

(4) To the extent to which a combined eligibility notice is not feasible for all members of the same household, applying on the same application, coordinated content must be provided for those household members whose eligibility status is not yet determined.

(c) Provision of Medicaid for individuals found eligible for Medicaid by another insurance affordability program. If the agency has entered into an agreement in accordance with §431.10(d) of this chapter under which the Exchange or other insurance affordability program makes final determinations of Medicaid eligibility, for each individual determined so eligible by the Exchange (including as a result of a decision made by the Exchange or Exchange appeals entity authorized under §431.10(c) of this chapter to adjudicate appeals of Medicaid eligibility determinations) or other program, the agency must--

* * * * *

(3) Include in the agreement into which the agency has entered under paragraph (b)(3) of this section that the Exchange or other insurance affordability program will provide combined eligibility notice of final eligibility determinations and appeals decisions made by it; and

(d) Transfer from other insurance affordability programs to the State Medicaid agency. For individuals for whom another insurance affordability program has not made a determination of Medicaid eligibility, but who have been assessed by such program (including as a result of a decision made by the Exchange appeals entity) as potentially Medicaid eligible, and for individuals not so assessed, but who otherwise request a full determination by the Medicaid agency, the agency must--

(1) Accept, via secure electronic interface, the electronic account for the individual and notify such program of the receipt of the electronic account.

(2) Not request information or documentation from the individual provided in the individual's electronic account, or to another insurance affordability program or appeals entity.

(3) Promptly and without undue delay, consistent with timeliness standards established under §435.912, determine the Medicaid eligibility of the individual, in accordance with §435.911 of this part, without requiring submission of another application, and –

(i) Effective January 1, 2015, for individuals determined eligible for Medicaid, provide combined eligibility notice, including notice of a denial or termination of the individual's eligibility for enrollment in a QHP through the Exchange or other insurance affordability programs, as applicable.

(ii) For individuals determined not eligible for Medicaid, comply with paragraph (e) of this section as if the individual had submitted an application to the agency.

(4) Accept any finding relating to a criterion of eligibility made by such program or appeals entity, without further verification, if such finding was made in accordance with policies and procedures which are the same as those applied by the agency or approved by it in the agreement described in paragraph (b)(3) of this section; and

(5) Notify such program of the final determination of the individual's eligibility or ineligibility for Medicaid.

(e) Evaluation of eligibility for other insurance affordability programs.

(1) Individuals determined not eligible for Medicaid. For individuals who submit an application or return a renewal form to the agency which includes sufficient information to determine Medicaid eligibility, or whose eligibility is being renewed pursuant to a change in circumstance in accordance with §435.916(d) of this part, and whom the agency determines are not eligible for Medicaid, and for individuals determined ineligible for Medicaid pursuant to fair hearing under subpart E of part 431 of this chapter, the agency must –

(i) Promptly and without undue delay, consistent with timeliness standards established under §435.912 of this part, determine potential eligibility for, and, as appropriate, transfer via a secure electronic interface the individual's electronic account to, other insurance affordability programs;

(ii) Include in any agreement into which the agency enters in accordance with paragraph (b)(3) of this section, that, effective January 1, 2015, such other program will issue a combined eligibility notice, including the agency's denial of Medicaid eligibility.

(iii) Prior to January 1, 2015—

(A) Include coordinated content, as defined in §435.4 of the part, in the notice of Medicaid denial or termination, provided to the individual in accordance with §435.917 of this part, relating to the transfer of the individual's account; or

(B) Include in the agreement into which the agency enters in accordance with (b)(3) of this section, that such other program will issue a combined eligibility notice, including the agency's denial of Medicaid eligibility.

(2) Individuals undergoing a Medicaid eligibility determination on a basis other than MAGI. In the case of an individual with household income greater than the applicable MAGI standard and for whom the agency is determining eligibility on another basis in accordance with §435.911(c)(2) of this part, the agency must promptly and without undue delay, consistent with timeliness standards established under §435.912 of this part –

(i) Determine potential eligibility for, and as appropriate, transfer via secure electronic interface the individual's electronic account to, other insurance affordability programs and provide timely notice to such other program –

(A) That the individual is not Medicaid eligible on the basis of the applicable MAGI standard, but that a final determination of Medicaid eligibility on other bases is still pending; and

(B) Of the agency's final determination of eligibility or ineligibility for Medicaid.

(ii) Provide notice to the individual, consistent with §435.917 of this part, that the agency–

(A) Has determined the individual ineligible for Medicaid on the basis of having household income at or below the applicable MAGI standard; and

(B) Is continuing to evaluate Medicaid eligibility on other bases, including a plain language explanation of the other bases being considered.

(C) Such notice must include coordinated content relating to the transfer of the individual's electronic account to the other insurance affordability program and explanation that eligibility for or enrollment in such program will not affect the determination of Medicaid eligibility on other bases; and

(iii) Provide the individual with notice, consistent with §435.917 of this part, of the final determination of eligibility on the other bases. In the case of individuals determined eligible for Medicaid on a basis other than having income at or below the applicable modified adjusted gross income standard, such notice also must contain coordinated content informing the individual of the notice provided to the Exchange or other program in accordance with paragraph (e)(2)(i)(II) of this section and that approval of Medicaid eligibility will result in termination of eligibility for and by the other program if the individual is enrolled in such program.

(3) The agency may enter into an agreement with the Exchange to make determinations of eligibility for enrollment in a QHP through the Exchange, advance payments of the premium tax credit and cost-sharing reductions, consistent with 45 CFR §155.110(a)(2).

* * * * *

(g) Coordination involving appeals entities. The agency must --

(1) Establish a secure electronic interface the through which –

(i) The Exchange can notify the agency that an appeal of eligibility for enrollment in a QHP through the Exchange, advance payments of the premium tax credit, or cost-sharing reductions, has been filed; and

(ii) The individual's electronic account, including any information provided by the individual as part of an appeal to either the agency or Exchange appeals entity, can be transferred from one program or appeals entity to the other.

(2) In conducting a fair hearing in accordance with subpart E or part 431 of this chapter, not request information or documentation from the individual included in the individual's electronic account or provided to the Exchange or Exchange appeals entity.

(3)(i) In the case of individuals described in paragraph (g)(3)(ii) of this section, transmit to the Exchange, through the electronic interface established under paragraph (g)(1)(i) of this section, the hearing decision made by the agency under part 431 subpart E;

(ii) Individuals described in this paragraph include individuals determined ineligible for Medicaid—

(A) By the Exchange; or

(B) By the agency and transferred to the Exchange in accordance with paragraph (e)(1) or (2) of this section.

97. Section 435.1205 is added to read as follows:

§435.1205 Alignment with exchange initial open enrollment period.

(a) References and definitions. For purposes of this section –

(1) March 23, 2012 final rule refers to the Final rule; Interim final rule published on March 23, 2012 at 77 Federal Register 17144.

(2) Eligibility based on MAGI means Medicaid eligibility based on the eligibility requirements which will be effective under the State plan, or waiver of such plan, as of January 1, 2014, consistent with §§435.110 – 435.119, 435.218 and 435.603 of the March 23, 2012 final

rule, as revised in subsequent rulemaking.

(3) Electronic account, insurance affordability program and secure electronic interface have the meanings provided in §435.4 of the March 23, 2012 final rule, as revised in subsequent rulemaking.

(b) The following are effective for purposes of this section as of October 1, 2013:

(1) Provisions of §431.10(c) of this chapter, as revised in the March 23, 2012 rule and subsequent rulemaking, relating to the agency's ability to delegate authority to make eligibility determinations to the Exchange;

(2) Sections 435.916 and 435.952 of the March 23, 2012 final rule, as revised in subsequent rulemaking.

(c) Medicaid agency responsibilities to achieve coordinated open enrollment. For the period beginning October 1, 2013 through December 31, 2013, the agency must

(1) Accept –

(i) The single streamlined application described in §435.907 of the March 23, 2012 final rule, as revised in subsequent rulemaking; and

(ii) Via secure electronic interface, an electronic account transferred from another insurance affordability program.

(2) With respect to eligibility based on MAGI effective January 1, 2014, comply with the terms of §435.1200 of this part, such that –

(i) For each electronic account transferred to the agency under paragraph (c)(1)(ii) of this section, the agency either –

(A) Consistent with §435.1200(c), accepts a determination of Medicaid eligibility based on MAGI, effective January 1, 2014, made by another insurance affordability program; or

(B) Consistent with §435.1200(d), determines eligibility for Medicaid based on MAGI, effective January 1, 2014.

(ii) Consistent with §435.1200(e), for each single streamlined application submitted directly to the agency under paragraph (b)(1)(i) of this section –

(A) Determine eligibility based on MAGI effective January 1, 2014; and

(B) For each individual determined not Medicaid eligible based on MAGI, determine potential eligibility for other insurance affordability programs, based on the requirements which will be effective for each program as of January 1, 2014, and transfer the individual's electronic account to such program via secure electronic interface.

(iii) Provide notice and fair hearing rights, in accordance with §435.917 of this part, part 431 subpart E of this chapter, and §435.1200 for those determined ineligible for Medicaid effective January 1, 2014.

(3) For each individual determined eligible based on MAGI in accordance with paragraph (c)(2) of this section –

(i) Provide notice, including the effective date of eligibility, to such individual, consistent with §435.917 of this part, and furnish Medicaid effective January 1, 2014.

(ii) Apply the terms of §435.916 (relating to beneficiary responsibility to inform the agency of any changes in circumstances that may affect eligibility) and §435.952 (regarding use of information received by the agency) of the March 23, 2012 final rule, as revised in subsequent rulemaking. The first renewal under §435.916 of this part may, at State option, be scheduled to occur anytime between 12 months from the date of application and 12 months from January 1, 2014.

(4) With respect to eligibility effective in 2013, for all applicants –

(i) Consistent with the requirements of subpart J of this part, and applying the eligibility requirements in effect under the State plan, or waiver of such plan, as of the date the individual submits an application to any insurance affordability program –

(A) Determine the individual's eligibility based on the information provided on the

application or in the electronic account; or

(B) Request additional information from the individual needed by the agency to determine eligibility based on the eligibility requirements in effect on such date, including on a basis excepted from application of MAGI-based methods, as described in §435.603 of the March 23, 2012 final rule, as revised in subsequent rulemaking, and determine such eligibility if such information is provided; and

(C) Furnish Medicaid to individuals determined eligible pursuant to this clause or provide notice and fair hearing rights in accordance with part 431 subpart E of this part if eligibility effective in 2013 is denied; or

(ii) Notify the individual of the opportunity to submit a separate application for coverage effective in 2013 and information on how to obtain and submit such application.

PART 440-SERVICES: GENERAL PROVISIONS

98. The authority citation for part 440 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

99. Section 440.130 is amended by revising paragraph (c) to read as follows:

§440.130 Diagnostic, screening, preventive, and rehabilitative services.

* * * * *

(c) Preventive services means services recommended by a physician or other licensed practitioner of the healing arts acting within the scope of authorized practice under State law.

* * * * *

100. Section 440.305 is amended by revising paragraphs (a) and (b) to reads as follows:

§440.305 Scope.

(a) General. This subpart sets out requirements for States that elect to provide medical assistance to certain Medicaid eligible individuals within one or more groups of individuals specified by the State, through enrollment of the individuals in coverage, identified as

"benchmark" or "benchmark-equivalent." Groups must be identified by characteristics of individuals rather than the amount or level of Federal matching funding.

(b) Limitations. A State may only apply the option in paragraph (a) of this section for an individual whose eligibility is based on an eligibility category under section 1905(a) of the Act that could have been covered under the State's plan on or before February 8, 2006, except that individuals who are eligible under 1902(a)(10)(A)(i)(VIII) must enroll in an Alternative Benefit Plan, unless meeting one of the exemptions listed in §440.315.

* * * * *

101. Section 440.315 is amended by revising the introductory text and paragraphs (f) and (h) to read as follows:

§440.315 Exempt individuals.

Individuals within one (or more) of the following categories are exempt from mandatory enrollment in an Alternative Benefit Plan.

* * * * *

(f) The individual is medically frail or otherwise an individual with special medical needs. For these purposes, the State's definition of individuals who are medically frail or otherwise have special medical needs must at least include those individuals described in §438.50(d)(3) of this chapter, individuals with disabling mental disorders (including children with serious emotional disturbances and adults with serious mental illness), individuals with serious and complex medical conditions, individuals with a physical, intellectual or developmental disability that significantly impairs their ability to perform 1 or more activities of daily living, or individuals with a disability determination based on Social Security criteria or in States that apply more restrictive criteria than the Supplemental Security Income program, the State plan criteria.

* * * * *

(h) The individual is eligible and enrolled for Medicaid under §435.145 of this title based on current eligibility for assistance under title IV-E of the Act or under §435.150 of this title based on current status as a former foster care child.

* * * * *

102. Section 440.330 is amended by revising paragraph (d) to read as follows:

§440.330 Benchmark health benefits coverage.

* * * * *

(d) Secretary-approved coverage**.** Any other health benefits coverage that the Secretary determines, upon application by a State, provides appropriate coverage to meet the needs of the population provided that coverage. Secretarial coverage may include benefits of the type that are available under 1 or more of the standard benchmark coverage packages defined in §440.330(a) through (c) of this chapter, State plan benefits described in section 1905(a), 1915(i), 1915(j), 1915(k) or section 1945 of the Act, any other Medicaid State plan benefits enacted under title XIX, or benefits available under base benchmark plans described in 45 CFR §156.100.

(1) States wishing to elect Secretarial approved coverage should submit a full description of the proposed coverage (including a benefit-by-benefit comparison of the proposed plan to one or more of the three other benchmark plans specified above or to the State's standard full Medicaid coverage package), and of the population to which coverage would be offered. In addition, the State should submit any other information that would be relevant to a determination that the proposed health benefits coverage would be appropriate for the proposed population.

(2) [Reserved]

103. Section 440.335 is amended by—

A. Adding paragraphs (b)(7)and (b)(8).

B. Revising paragraph (c)(1).

The revisions and additions read as follows:

§440.335 Benchmark-equivalent health benefits coverage.

* * * * *

(b) * * *

(7) Prescription drugs.

(8) Mental health benefits.

(c) (1) Additional Coverage. In addition to the types of benefits of this section, benchmark-equivalent coverage may include coverage for any additional benefits of the type which are covered in 2 or more of the standard benchmark coverage packages described in §440.330(a through c) of this part or State plan benefits, described in section 1905(a), 1915(i), 1915(j), 1915(k) and 1945 of the Act, any other Medicaid State plan benefits enacted under title XIX, or benefits available under base benchmark plans described in §156.100.

* * * * *

104. Section 440.345 is amended by—

A. Revising the section heading.

B. Adding paragraphs (b) through (e).

The revision and additions read as follows:

§440.345 EPSDT and other required benefits.

* * * * *

(b) Family planning. Alternative Benefit Plans must include coverage for family planning services and supplies.

(c) Mental health parity. Alternative Benefit Plans that provide both medical and surgical benefits, and mental health or substance use disorder benefits, must comply with the Mental Health Parity and Addiction Equity Act.

(d) Essential health benefits. Alternative Benefit Plans must include at least the essential health benefits described in §440.347, and include all updates or modifications made thereafter by the Secretary to the definition of essential health benefits.

(e) Updating of benefits. States are not required to update Alternative Benefit Plans that have been determined to include essential health benefits as of January 1, 2014, until December 31, 2015. States will adhere to future guidance for updating benefits beyond that date, as described by the Secretary.

105. Section 440.347 is added to read as follows:

§440.347 Essential health benefits.

(a) Alternative benefit plans must contain essential health benefits coverage, including benefits in each of the following ten categories, consistent with the requirements set forth in 45 CFR Part 156:

(1) Ambulatory patient services;

(2) Emergency services;

(3) Hospitalization;

(4) Maternity and newborn care;

(5) Mental health and substance use disorders, including behavioral health treatment;

(6) Prescription drugs;

(7) Rehabilitative and habilitative services and devices;

(8) Laboratory services;

(9) Preventive and wellness services and chronic disease management; and

(10) Pediatric services, including oral and vision care.

(b) Alternative benefit plans must include at least the essential health benefits included in one of the state options for establishing essential health benefits described in 45 CFR Part 156.

(c) States may select more than one option for establishing essential health benefits in keeping with the flexibility for States to implement more than one alternative benefit plan for targeted populations.

(d) [Reserved]

(e) Essential health benefits cannot be based on a benefit design or implementation of a benefit design that discriminates on the basis of an individual's age, expected length of life, or of an individual's present or predicted disability, degree of medical dependency, or quality of life or other health conditions.

106. Section 440.360 is revised to read as follows:

§440.360 State plan requirements for providing additional services.

In addition to the requirements of §440.345, the State may elect to provide additional coverage to individuals enrolled in alternative benefit plans, except that the coverage for individuals eligible only through section 1902(a)(10)(A)(i)(VIII) of the Act who are not exempt is limited to benchmark or benchmark equivalent coverage. The State must describe the populations covered and the payment methodology for these benefits. Additional benefits must be benefits of the type, which are covered in one or more of the standard benchmark coverage packages described in §440.330(a) through (c) or State plan benefits including those described in sections 1905(a), 1915(i), 1915(j), 1915(k) and 1945 of the Act and any other Medicaid State plan benefits enacted under title XIX, or benefits available under base benchmark plans described in section §156.100.

107. Section 440.386 is added to read as follows:

§440.386 Public notice.

States submitting to a State plan amendment to establish an alternative benefit plan, or an amendment to modify an existing alternative benefit plan, must provide the public with notification of such an amendment and reasonable opportunity to comment with respect to such

amendment, have included in the notice a description of the method of assuring compliance with §440.345 of this part related to full access to EPSDT services and the method for complying with the provisions of section 5006(e) of the American Recovery and Reinvestment Act of 2009.

(a) Public notice must take place no less than 2 weeks prior to submission of any SPA that seeks to:

(1) Establish an alternative benefit plan that would provide coverage that is less than the coverage provided by the State's approved State plan or includes cost sharing of any type.

(2) Modify an approved alternative benefit plan by adding or increasing cost-sharing, or reducing benefits.

(b) Public notice must take place prior to the implementation of any SPA that seeks to:

(1) Establish an alternative benefit plan that provides the same or more benefits than currently are provided in the State's approved State plan.

(2) Modify an approved alternative benefit plan by reducing cost-sharing or adding additional benefits.

PART 447—PAYMENTS FOR SERVICES

108. The authority citation for part 447 continues to read as follows:

Authority: Section 1102 of the Social Security Act (42 U.S.C. 1302).

109. Section 447.50 is revised to read as follows:

§447.50 Premiums and cost sharing: Basis and purpose

Sections 1902(a)(14), 1916 and 1916A of the Act permit states to require certain beneficiaries to share in the costs of providing medical assistance through premiums and cost sharing. Sections 447.52 through 447.56 specify the standards and conditions under which states may impose such premiums and or cost sharing.

110. Section 447.51 is revised to read as follows:

§447.51 Definitions

As used in this part –

Alternative non-emergency services provider means a Medicaid provider, such as a physician's office, health care clinic, community health center, hospital outpatient department, or similar provider that can provide clinically appropriate services in a timely manner.

Cost sharing means any copayment, coinsurance, deductible, or other similar charge.

Emergency services has the same meaning as in §438.114 of this part.

Indian means any individual defined at 25 U.S.C. 1603 or 1679(b), or who has been determined eligible as an Indian, pursuant to §136.12 of this part, or meets any of the following criteria:

(1) Is a member of a Federally-recognized Indian tribe;

(2) Resides in an urban center and meets one or more of the following four criteria:

(i) Is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member;

(ii) Is an Eskimo or Aleut or other Alaska Native;

(iii) Is considered by the Secretary of the Interior to be an Indian for any purpose; or

(iv) Is determined to be an Indian under regulations promulgated by the Secretary;

(3) Is considered by the Secretary of the Interior to be an Indian for any purpose; or

(4) Is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.

Indian health care provider means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care

Improvement Act (25 U.S.C. 1603).

Non-emergency services means any care or services that are not considered emergency services as defined in this section and any services furnished in a hospital emergency department that do not constitute an appropriate medical screening examination or stabilizing examination and treatment required to be provided by the hospital under section 1867 of the Act.

Preferred drugs means drugs that the state has identified on a publicly available schedule as being determined by a pharmacy and therapeutics committee for clinical efficacy as the most cost effective drugs within each therapeutically equivalent or therapeutically similar class of drugs, or all drugs if the agency does not differentiate between preferred and non-preferred drugs.

Premium means any enrollment fee, premium, or other similar charge.

111. Section 447.52 is revised to read as follows:

§447.52 Cost sharing.

(a) Except as provided in §447.56 of this part, the agency may impose cost sharing for any service under the state plan.

(b) Maximum Allowable Cost Sharing. (1) At State option, cost sharing imposed for any service (other than for drugs and emergency department services, as described in §§447.53 and 447.54 respectively) may be established at or below the amounts shown in the following table (except that the maximum allowable cost for individuals with family income at or below 100 percent of the FPL shall be increased each year, beginning October 1, 2015, by the percentage increase in the medical care component of the CPI-U for the period of September to September of the preceding calendar year, rounded to the next higher 5-cent increment):

	Individuals with Family Income ≤100% FPL	**Individuals with Family Income 101-150% FPL**	**Individuals with Family Income >150% FPL**

Outpatient Services *(physician visit, physical therapy, etc.)*	$4	10% of cost the agency pays	20% of cost the agency pays
Inpatient Stay	50% of cost the agency pays for the first day of care	50% of cost the agency pays for the first day of care or 10% of total cost the agency pays for the entire stay	50% of cost the agency pays for the first day of care or 20% of total cost the agency pays for the entire stay

(2) In states that do not have fee-for-service payment rates, any cost sharing imposed may not exceed the maximum amount established in paragraph (b)(1) of this section, for individuals with income at or below 100 percent of the applicable Federal Poverty Guidelines.

(3) In no case shall the maximum cost sharing established by the agency be equal to or exceed the amount the agency pays for the service.

(c) Targeted cost sharing. For individuals with family income above 100 percent of the applicable Federal Poverty Guidelines, cost sharing may be targeted to specified groups of individuals within the applicable income group.

(d) Denial of service for nonpayment. (1) The agency may permit a provider, including a pharmacy or hospital, to require an individual to pay cost sharing as a condition for receiving the item or service if—

(i) The individual has family income above 100 percent of the applicable Federal Poverty Guidelines,

(ii) The individual is not part of an exempted group under §447.56(a) of this part, and

(iii) With respect to cost sharing imposed for non-emergency services furnished in an emergency department, the conditions under §447.54(d) have been satisfied.

(2) Except as provided under paragraph (d)(1) of this section, the state plan must specify that no provider may deny services to an eligible individual on account of the individual's inability to pay the cost sharing.

(3) Nothing in this section shall be construed as prohibiting a provider from choosing to reduce or waive such cost sharing on a case-by-case basis.

(e) Prohibition against multiple charges. For any service, the agency may not impose more than one type of cost sharing.

(f) State Plan Specifications. For each cost sharing charge imposed under this section, the state plan must specify—

(1) The service for which the charge is made;

(2) The group or groups of individuals that may be subject to the charge;

(3)The amount of the charge;

(4) The process used by the state to identify which beneficiaries are subject to cost sharing and to ensure individuals exempt from cost sharing are not charged, including the process used by the state to identify for providers whether cost sharing for a specific item or service may be imposed on an individual beneficiary and whether the provider may require the beneficiary, as a condition for receiving the item or service, to pay the cost sharing charge; and

(5) If the agency imposes cost sharing under §447.54, the process by which services are identified as non-emergent.

112. Section 447.53 is revised to read as follows:

§447.53 Cost sharing for drugs.

(a) The agency may establish differential cost sharing for preferred and non-preferred drugs. The provisions in §447.56(a) shall apply except as the agency exercises the option under paragraph (d) of this section. All drugs will be considered preferred drugs if so identified or if the agency does not differentiate between preferred and non-preferred drugs.

(b) At state option, cost sharing for drugs may be established at or below the amounts shown in the following table (except that the maximum allowable cost sharing shall be increased each year, beginning October 1, 2015, by the percentage increase in the medical care component of

the CPI-U for the period of September to September of the preceding calendar year, rounded to the next higher 5-cent increment. Such increase shall not be applied to any cost sharing that is based on the amount the agency pays for the service):

	Individuals with Family Income ≤ 150% FPL	**Individuals with Family Income >150% FPL**
Preferred Drugs	$4	$4
Non-Preferred Drugs	$8	20% of cost the agency pays

(c) In states that do not have fee-for-service payment rates upon which to base the payment, cost sharing may not exceed the maximum amount established under paragraph (b) of this section for individuals with income at or below 150 percent of the FPL.

(d) For individuals otherwise exempt from cost sharing under §447.56(a), the agency may impose cost sharing for non-preferred drugs, not to exceed the maximum amount established in paragraph (b) of this section for preferred drugs.

(e) In the case of a drug that is identified by the agency as a non-preferred drug within a therapeutically equivalent or therapeutically similar class of drugs, the agency must have a process in place so that cost sharing is limited to the amount imposed for a preferred drug if the individual's prescribing physician determines that the preferred drug for treatment of the same condition either would be less effective for the individual or would have adverse effects for the individual or both. In such cases the agency must ensure that reimbursement to the pharmacy is based on the appropriate cost sharing amount.

113. Section 447.54 is revised to read as follows:

§447.54 Cost sharing for services furnished in a hospital emergency department.

(a) The agency may impose cost sharing for non-emergency services provided in a hospital emergency department (ED). The provisions in §447.56(a) shall apply except as the

agency exercises the option under paragraph (c) of this section.

(b) At state option, cost sharing for non-emergency services provided in an ED may be established at or below the amounts shown in the following table (except that the maximum allowable cost sharing identified for individuals with family income at or below 150 percent of the FPL shall be increased each year, beginning October 1, 2015, by the percentage increase in the medical care component of the CPI-U for the period of September to September of the preceding calendar year, rounded to the next higher 5-cent increment):

	Individuals with Family Income ≤ 150% FPL	**Individuals with Family Income >150% FPL**
Non-emergency Use of the Emergency Department	$8	No Limit

(c) For individuals otherwise exempt from cost sharing under §447.56(a), the agency may impose cost sharing for non-emergency use of the ED, not to exceed the maximum amount established in paragraph (a) of this section for individuals with income at or below 150 percent of the FPL.

(d) In order for the agency to impose cost sharing under paragraph (a) or (c) of this section for non-emergency use of the ED, the hospital providing the care must—

(1) Conduct an appropriate medical screening pursuant to §489.24 of this chapter to determine that the individual does not need emergency services.

(2) Before providing treatment and imposing cost sharing on an individual:

(i) Provide the individual with the name and location of an available and accessible alternative non-emergency services provider;

(ii) Ensure that the alternative provider can provide services to the individual in a timely manner with the imposition of a lesser cost sharing amount or no cost sharing if the individual is

otherwise exempt from cost sharing; and

(iii) Coordinate scheduling and provide a referral for treatment by this provider.

(e) Nothing in this section shall be construed to:

(1) Limit a hospital's obligations with respect to screening and stabilizing treatment of an emergency medical condition under section 1867 of the Act; or

(2) Modify any obligations under either state or federal standards relating to the application of a prudent-layperson standard with respect to payment or coverage of emergency medical services by any managed care organization.

114. Section 447.55 is revised to read as follows:

§447.55 Premiums.

(a) The agency may impose premiums upon individuals whose income exceeds 150 percent of the FPL, subject to the exemptions set forth in §447.56(a) and the aggregate limitations set forth in §447.56(f), except that:

(1) Pregnant women described in subparagraph (A) of section 1902(l)(1) of the Act who are receiving medical assistance on the basis of section 1902(a)(10)(A)(ii)(IX) of the Act, whose income exceeds 150 percent of the FPL, may be charged premiums that do not exceed 10 percent of the amount by which their family income exceeds 150 percent of the FPL after deducting expenses for care of a dependent child.

(2) Individuals provided medical assistance only under section 1902(a)(10)(A)(ii)(XV) or section 1902(a)(10)(A)(ii)(XVI) of the Act and the Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA), may be charged premiums on a sliding scale based on income.

(3) Disabled children provided medical assistance under section 1902(a)(10)(A)(ii)(XIX) of the Act in accordance with the Family Opportunity Act, may be charged premiums on a sliding scale based on income. The aggregate amount of the child's premium imposed under this

paragraph and any premium that the parent is required to pay for family coverage under section 1902(cc)(2)(A)(i) of the Act, and other cost sharing charges may not exceed:

(i) 5 percent of the family's income if the family's income is no more than 200 percent of the FPL.

(ii) 7.5 percent of the family's income if the family's income exceeds 200 percent of the FPL but does not exceed 300 percent of the FPL.

(4) Qualified disabled and working individuals described in section 1905(s) of the Act, may be charged premiums on a sliding scale based on income, expressed as a percentage of Medicare cost sharing described at section 1905(p)(3)(A)(i) of the Act.

(5) Medically needy individuals, as defined in §§435.4 and 436.3 of this subchapter, may be charged on a sliding scale not to exceed $20 per month.

(b) State plan specifications. For each premium, enrollment fee, or similar charge imposed under paragraph (a) or (b) of this section, the plan must specify—

(1) The group or groups of individuals that may be subject to the charge;

(2) The amount and frequency of the charge;

(3) The process used by the state to identify which beneficiaries are subject to premiums and to ensure individuals exempt from premiums are not charged; and

(4) The consequences for an individual or family who does not pay.

(c) Consequences for non-payment. (1) With respect to premiums imposed under paragraph (a) (1) of this section, the agency may—

(i) Require a group or groups of individuals to prepay; and

(ii) Terminate an individual from medical assistance on the basis of failure to pay for 60 days or more.

(2) With respect to premiums imposed under paragraphs (a)(2) and (4), the agency—

(i) May not require prepayment;

(ii) May terminate an individual from medical assistance on the basis of failure to pay the premium for 60 days or more; and

(iii) Specific to premiums imposed under paragraph (a)(2) of this section, permit state or local funds available under other programs to be used for payment of a premium. Such funds shall not be counted as income to the individual with respect to whom such payment is made.

(3) With respect to premiums imposed under paragraph (a)(3) of this section—

(i) For individuals with annual income exceeding 250 percent of the FPL, the agency may require payment of 100 percent of the premiums imposed under this paragraph for a year, such that payment is only required up to 7.5 percent of annual income for individuals whose annual income does not exceed 450 percent of the FPL.

(ii) For individuals whose annual adjusted gross income (as defined in section 62 of the Internal Revenue Code of 1986) exceeds $75,000, increased by inflation each calendar year after 2000, the agency must require payment of 100 percent of the premiums for a year, except that the agency may choose to subsidize the premiums using state funds which may not be federally matched by Medicaid.

(4) With respect to any premiums imposed under this section, the agency may waive payment of a premium in any case where the agency determines that requiring the payment would create an undue hardship for the individual or family.

115. Section 447.56 is revised to read as follows:

§447.56 Limitations on premiums and cost sharing.

(a) Exemptions. (1) The agency may not impose premiums or cost sharing upon the following groups of individuals:

(i) Children under 18 years of age (and, at the option of the State, individuals under 21, 20, or 19 years of age, or any reasonable category of individuals 18 years of age or over but under 21) who either have family income at or below 100 percent of the FPL or are described in

section 1902(a)(10)(A)(i) of the Act.

(ii) Children for whom child welfare services are made available under Part B of title IV of the Act on the basis of being a child in foster care and individuals with respect to whom adoption or foster care assistance is made available under Part E of that title, without regard to age.

(iii) Disabled children, except as provided at §447.55(a)(4)(premiums), who are receiving medical assistance by virtue of the application of the Family Opportunity Act in accordance with sections 1902(a)(10)(A)(ii)(XIX) and 1902(cc) of the Act.

(iv) Pregnant women, except as provided in paragraph (2)(cost sharing) and §447.55(a)(2)(premiums), during the pregnancy and through the postpartum period which begins on the last day of pregnancy and extends through the end of the month in which the 60-day period following termination of pregnancy ends.

(v) Any individual who, as a condition of receiving services in an institution is required to spend all but a minimal amount of the individual's income required for personal needs. At state option, this exemption may be applied to individuals receiving services in a home and community-based setting if they are required to contribute to the cost of their care.

(vi) An individual receiving hospice care, as defined in section 1905(o) of the Act.

(vii) An Indian who is eligible to receive or has received an item or service furnished by an Indian health care provider or through referral under contract health services is exempt from premiums. Indians who are currently receiving or have ever received an item or service furnished by an Indian health care provider or through referral under contract health services are exempt from all cost sharing.

(viii) Individuals who are receiving Medicaid because of the state's election to extend coverage as authorized by § 435.213 (Breast and Cervical Cancer).

(2) The agency may not impose cost sharing for the following services:

(i) Emergency services as defined at section 1932(b)(2) of the Act and §438.114(a);

(ii) Family planning services and supplies described in section 1905(a)(4)(C) of the Act, including contraceptives and pharmaceuticals for which the State claims or could claim Federal match at the enhanced rate under section 1903(a)(5) of the Act for family planning services and supplies;

(iii) Preventive services, at a minimum the services specified at §457.520, provided to children under 18 years of age regardless of family income, which reflect the well-baby and well child care and immunizations in the Bright Futures guidelines issued by the American Academy of Pediatrics; and

(iv) Pregnancy-related services, including those defined at §§440.210(a)(2) and 440.250(p), and counseling and drugs for cessation of tobacco use All services provided to pregnant women will be considered as pregnancy-related, except those services specifically identified in the state plan as not being related to the pregnancy.

(b) Applicability. Except as permitted under **§**447.52(c) (targeted cost sharing), the agency may not exempt additional individuals from cost sharing obligations that apply generally to the population at issue.

(c) Payments to providers. (1) Except as provided under paragraphs (c)(2) and (c)(3) of this section, the agency must reduce the payment it makes to a provider by the amount of a beneficiary's cost sharing obligation, regardless of whether the provider has collected the payment or waived the cost sharing.

(2) For items and services provided to Indians who are exempt from cost sharing under paragraph (a)(1)(vii) of this section, the agency may not reduce the payment it makes to a provider, including an Indian health care provider, by the amount of cost sharing that would otherwise be due from the Indian.

(3) For those providers that the agency reimburses under Medicare reasonable cost

reimbursement principles, in accordance with subpart B of this part, an agency may increase its payment to offset uncollected deductible, coinsurance, copayment, or similar charges that are bad debts of providers.

(d) Payments to managed care organizations. If the agency contracts with a managed care organization, the agency must calculate its payments to the organization to include cost sharing established under the state plan, for beneficiaries not exempt from cost sharing under paragraph (a) of this section, regardless of whether the organization imposes the cost sharing on its recipient members or the cost sharing is collected.

(e) Payments to states. No FFP in the state's expenditures for services is available for—

(1) Any premiums or cost sharing amounts that recipients should have paid under §§447.52 through 447.55 (except for amounts that the agency pays as bad debts of providers under paragraph (a)(3) of this section; and

(2) Any amounts paid by the agency on behalf of ineligible individuals, whether or not the individual had paid any required premium, except for amounts for premium assistance to obtain coverage for eligible individuals through family coverage that may include ineligible individuals when authorized in the approved state plan.

(f) Aggregate limits. (1) Subject to paragraph (f)(2) of this section, any Medicaid premiums and cost sharing incurred by all individuals in the Medicaid household may not exceed an aggregate limit of 5 percent of the family's income applied on either a quarterly or monthly basis, as specified by the agency.

(2) The aggregate limit in paragraph (f)(1) of this section shall apply when premiums and cost sharing are imposed on any of the following individuals:

(i) Individuals who are subject to targeted cost sharing under §447.52(c);

(ii) Individuals who are subject to enforceable cost sharing under §447.52(d);

(iii) Individuals who are subject to premiums under §447.55(a)(1); and

(iv) Individuals exempt from premiums and cost sharing under paragraph (a) of this section who are subject to cost sharing for non-preferred drugs under §447.53 or non-emergency services furnished in an emergency department under §447.54.

(3) If the state adopts premiums or cost sharing rules that could place beneficiaries at risk of reaching the aggregate family limit, the state plan must indicate a process to track each family's incurred premiums and cost sharing through an automated mechanism that does not rely solely on beneficiary documentation.

(4) The agency must notify beneficiaries and providers when a beneficiary has incurred out-of-pocket expenses up to the aggregate family limit and individual family members are no longer subject to cost sharing for the remainder of the family's current monthly or quarterly cap period.

(5) The agency must have a process in place for beneficiaries to request a reassessment of their family aggregate limit if they have a change in circumstances or if they are being terminated for failure to pay a premium.

(6) Nothing in this paragraph shall preclude the agency from establishing additional aggregate limits, including but not limited to a monthly limit on cost sharing charges for a particular service.

116. Section 447.57 is revised to read as follows:

§447.57 Beneficiary and public notice requirements.

(a) The agency must make available a public schedule describing current premiums and cost sharing requirements containing the following information:

(1) The group or groups of individuals who are subject to premiums and/or cost sharing and the current amounts;

(2) Mechanisms for making payments for required premiums and cost sharing charges;

(3) The consequences for an applicant or recipient who does not pay a premium or cost

sharing charge;

(4) A list of hospitals charging cost sharing for non-emergency use of the emergency department; and

(5) A list of preferred drugs or a mechanism to access such a list, including the agency website.

(b) The agency must make the public schedule available to the following in a manner that ensures that affected applicants, beneficiaries, and providers are likely to have access to the notice:

(1) Beneficiaries, at the time of their enrollment and reenrollment after a redetermination of eligibility, and when premiums, cost sharing charges, or aggregate limits are revised, notice to beneficiaries must be in accordance with §435.905(b);

(2) Applicants, at the time of application;

(3) All participating providers; and

(4) The general public.

(c) Prior to submitting to the Centers for Medicare & Medicaid Services for approval a state plan amendment (SPA) to establish or substantially modify existing premiums or cost sharing, or change the consequences for non-payment, the agency must provide the public with advance notice of the SPA, specifying the amount of premiums or cost sharing and who is subject to the charges. The agency must provide a reasonable opportunity to comment on such SPAs. The agency must submit documentation with the SPA to demonstrate that these requirements were met.

§447.58 [Removed and Reserved]

117. Section 447.58 is removed and reserved.

§447.59 [Removed and Reserved]

118. Section 447.59 is removed and reserved.

§447.60 [Removed and Reserved]

119. Section 447.60 is removed and reserved.

§447.62 [Removed and Reserved]

120. Section 447.62 is removed and reserved.

§447.64 [Removed and Reserved]

121. Section 447.64 is removed and reserved.

PART 457—ALLOTMENTS AND GRANTS TO STATES

122. The authority citation for part 457 continues to read as follows:

Authority: Section 1102 of the Social Security Act (42 U.S.C. 1302).

123. Section 457.10 is amended by—

A. Revising the definition of "electronic account."

B. Adding the definitions of "Combined eligibility notice," "Coordinated content," "Exchange appeals entity," and "Premium Lock Out" in alphabetical order.

The additions and revisions read as follows:

§457.10 Definitions and use of terms.

* * * * *

Combined eligibility notice means an eligibility notice that informs an individual, or multiple family members of a household when feasible, of eligibility for each of the insurance affordability programs and enrollment in a qualified health plan through the Exchange, for which a determination or denial was made. A combined eligibility notice shall be issued by the last agency to make a determination of eligibility, regardless of which entity received the application. A combined notice must meet the requirements of §457.340(e) of this part and contain the content described in §457.340(e)(1) of this part, except that information described in §457.340(e)(1)(i)(C) must be included in a combined notice issued by another insurance affordability program only if known to that program.

Coordinated content means information included in an eligibility notice regarding the transfer of the individual's or households' electronic account to another insurance affordability program for a determination of eligibility.

* * * * *

Electronic account means an electronic file that includes all information collected and generated by the State regarding each individual's CHIP eligibility and enrollment, including all documentation required under §457.380 of this part and including any information collected or generated as part of a review conducted in accordance with subpart K of this part.

* * * * *

Exchange appeals entity has the meaning given to the term "appeals entity," as defined in 45 CFR 155.500.

* * * * *

Premium Lock-Out is defined as a State-specified period of time not to exceed 90 days that a CHIP eligible child who has an unpaid premium or enrollment fee (as applicable) will not be permitted to reenroll for coverage in CHIP. Premium lock-out periods are not applicable to children who have paid outstanding premiums or enrollment fees.

* * * * *

124. Section 457.50 is revised to read as follows:

§457.50 State plan.

The State plan is a comprehensive Statement, submitted using an automated process by the State to CMS.

(a) States with approved paper State plans shall submit conversion plans to comply with the required automated format, with full compliance not later than 1 year following the availability of the automated template.

(b) Thereafter, approved paper State plans or plan amendments shall be valid only temporarily to the extent specifically authorized and incorporated by reference under the approved automated State plan.

125. Section 457.60 is amended by revising the introductory text to read as follows:

§457.60 Amendments.

A State may seek to amend its approved State plan in whole or in part at any time through the automated submission of an amendment to CMS.

* * * * *

126. Section 457.110 is amended by revising paragraph (a) to read as follows:

§ 457.110 Enrollment assistance and information requirements.

(a) Information disclosure. The State must make accurate, easily understood, information available to families of potential applicants, applicants and enrollees, and provide assistance to these families in making informed decisions about their health plans, professionals, and facilities. This information shall be provided in plain language and is accessible to individuals with disabilities and persons who are limited English proficient, consistent with §435.905(b) of this part.

(1) The State may provide notices to applicants and beneficiaries in electronic format, provided that the State establish safeguards in accordance with § 435.918 of this chapter.

(2) [Reserved]

* * * * *

127. Section §457.310 is amended by revising paragraph (b)(2)(i) to read as follows:

§457.310 Targeted low-income child.

* * * * *

(b) * * *

(2) * * *

(i) Found eligible or potentially eligible for Medicaid under policies of the State plan (determined through either the Medicaid application process or the screening process described at §457.350 of this part), except for eligibility under §435.214 of this chapter (related to coverage for family planning services).

* * * * *

128. Section 457.320 is amended by--

A. Republishing paragraph (b) introductory text.

B. Revising paragraph (b)(6).

C. Redesignating paragraphs (c), (d), and (e) as paragraphs (d), (e), and (f), respectively.

D. Adding paragraph (c).

E. Revising newly redesignated paragraph (d).

The addition and revisions read as follows:

§457.320 Other eligibility standards.

* * * * *

(b) Prohibited eligibility standards. In establishing eligibility standards and methodologies, a State may not--

* * * * *

(6) Exclude individuals based on citizenship or nationality, to the extent that the children are U.S. citizens or U.S. nationals, or qualified non-citizens as defined in §435.4 of this chapter, (except to the extent that 8 U.S.C. sections 1611, 1613, and 1641 precludes them from receiving Federal means-tested public benefits), as verified in accordance with §457.380 of this part.

* * * * *

(c) Option to Cover Non-citizen Children and/or Pregnant Women. The State may cover non-citizen children or pregnant women who are lawfully present in the United States, as defined

in §435.4 of this chapter, but whose CHIP eligibility would otherwise be prohibited under §457.320(b)(6) of this part, and otherwise meet the eligibility requirements for the CHIP program under this part or section 2112 of the Act, provided that the State has elected to provide Medicaid to the same population.

(d) Citizenship and immigration status. All individuals, themselves or an adult member of the individual's family or household, an authorized representative, or if the individual is a minor or incapacitated, someone acting responsibly for the individual, provided that such individual attests to having reasonable basis to make a declaration of such status, seeking coverage under a separate child health plan, must declare to be a citizen or national of the United States or a non-citizen in a satisfactory immigration status.

* * * * *

129. Section 457.340 is amended by revising paragraphs (a) and (e) to read as follows:

§ 457.340 Application for and enrollment in CHIP.

(a) Application and renewal assistance, availability of program information, and Internet Website. The terms of §435.905, §435.906, §435.907(h), §435.908, 435.909, and §435.1200(f) of this chapter apply equally to the State in administering a separate CHIP.

* * * * *

(e) Notice of eligibility determinations. The State must provide each applicant or enrollee with timely and adequate written notice of any decision affecting their eligibility, including denial or termination, or suspension of eligibility, consistent with §457.315, 457.348, and 457.350 of this part. The notice must be written in plain language; and accessible to persons who are limited English proficient and individuals with disabilities, consistent with §435.905(b) of this chapter and §457.110 of this part.

(1) Content of eligibility notice.

(i) Notice of approved eligibility. Any notice of an approval of CHIP eligibility must include, but is not limited to the following information-

(A) The basis and effective date of eligibility;

(B) The circumstances under which the individual must report, and procedures for reporting, any changes that may affect the individual's eligibility;

(C) Information on benefits and services and if applicable, information relating to any premiums, enrollment fees, and cost sharing required, and information on the enrollee's right and responsibilities, including the opportunity for review of matters described in §457.1130 of this part.

(ii) Notice of adverse action including denial, termination or suspension of eligibility. Any notice of denial, termination, or suspension of CHIP eligibility must contain-- —

(A) The basis supporting the action and the effective date,

(B) Information on the individual's right to a review process, in accordance with §457.1180 of this part;

(iii) In the case of a suspension or termination of eligibility, the State must provide sufficient notice to enable the child's parent or other caretaker to take any appropriate actions that may be required to allow coverage to continue without interruption.

* * * * *

130. Section 457.342 is added to read as follows:

§457.342 Continuous eligibility for children.

(a) A State may provide continuous eligibility for children under CHIP consistent with §435.926.

(b) Besides as provided in §435.926(d) of this chapter, continuous eligibility may also be terminated for failure to pay required premiums or enrollment fees as provided for in the CHIP State plan.

131. Section 457.348 is amended by--

A. Redesignating paragraphs (a) through (d) as paragraphs (b) through (e), respectively.

B. Adding new paragraph (a).

C. Revising newly redesignated paragraphs (b), (c) and (d).

The revisions and additions read as follows:

§457.348 Determinations of Children's Health Insurance Program eligibility by other insurance affordability programs.

(a) Definitions.

Combined eligibility notice has the meaning as provided in §457.10 of this part.

Coordinated content has the meaning as provided in §457.10 of this part.

(b) Agreements with other insurance affordability programs. The State must enter into and, upon request, provide to the Secretary one or more agreements with the Exchange and the agencies administering other insurance affordability programs as are necessary to fulfill the requirements of this section, including a clear delineation of the responsibilities of each program to--

(1) Minimize burden on individuals seeking to obtain or renew eligibility or to appeal a determination of eligibility with respect to one or more insurance affordability program;

(2) Ensure compliance with paragraph (c) of this section, §457.350 of this part, and if applicable, paragraph (d) of this section;

(3) Ensure prompt determination of eligibility and enrollment in the appropriate program without undue delay, consistent with the timeliness standards established under §457.340(d) of this part, based on the date the application is submitted to any insurance affordability program, and

(i) Provide for a combined notice to individuals, as well as multiple members of the same households applying on the same application to the maximum extent feasible and as expressly required in this section, for all insurance affordability programs.

(ii) To the extent to which a combined eligibility notice is not feasible for all members of the same household, applying on the same application, coordinated content must be provided for those household members whose eligibility status is not yet determined.

(c) Provision of CHIP for individuals found eligible for CHIP by another insurance affordability program. If a State accepts final determinations of CHIP eligibility made by another insurance affordability program, for each individual determined so eligible by the other insurance affordability program (including as a result of a decision made by the Exchange appeals entity authorized by the State to adjudicate reviews of CHIP eligibility determinations), the State must--

(1) Establish procedures to receive, via secure electronic interface, the electronic account containing the determination of CHIP eligibility;

(2) Comply with the provisions of §457.340 of this part to the same extent as if the application had been submitted to the State.

(3) Include in the agreement into which the State has entered under paragraph (b) of this section that the Exchange or other insurance affordability program will provide combined eligibility notice of final eligibility determinations made by it; and

(4) Maintain proper oversight of the eligibility determinations made by the other program.

(d) Transfer from other insurance affordability programs to CHIP. For individuals for whom another insurance affordability program has not made a determination of CHIP eligibility, but who have been screened as potentially CHIP eligible by such program (including as a result of a decision made by the Exchange appeals entity), the State must --

(1) Accept, via secure electronic interface, the electronic account for the individual and notify such program of the receipt of the electronic account.

(2) Not request information or documentation from the individual already provided to the other insurance affordability program and included in the individual's electronic account or other transmission from the other program or appeals entity;

(3) Promptly and without undue delay, consistent with the timeliness standards established under §457.340(d) of this part, determine the CHIP eligibility of the individual, in accordance with §457.340 of this part, without requiring submission of another application;

(i) Effective January 1, 2015, for individuals determined eligible for CHIP, provide combined eligibility notice, including of a denial or termination of eligibility for other insurance affordability programs, as applicable.

(ii) For individuals determined not eligible for CHIP, comply with §457.350(i) of this section.

(4) Accept any finding relating to a criterion of eligibility made by such program or appeals entity, without further verification, if such finding was made in accordance with policies and procedures which are the same as those applied by the State in accordance with §457.380 of this part or approved by it in the agreement described in paragraph (a) of this section;

(5) Notify such program of the final determination of the individual's eligibility or ineligibility for CHIP.

* * * * *

132. Section 457.350 is amended by revising paragraph (b) introductory text and paragraphs (f), (g), (h), (i), and (j) to read as follows:

§457.350 Eligibility screening and enrollment in other insurance affordability programs.

* * * * *

(b) A State must, promptly and without undue delay, consistent with the timeliness standards established under §457.340(d) of this subpart, identify potential eligibility for other insurance affordability programs of any applicant , enrollee, or other individual who submits an application or renewal form to the State which includes sufficient information to determine CHIP eligibility, or whose eligibility is being renewed under a change in circumstance in accordance with §457.343 of this subpart or who is determined not eligible for CHIP pursuant to a review conducted in accordance with subpart K of this part, as follows:

* * * * *

(f) Applicants found potentially eligible for Medicaid based on modified adjusted gross income. For individuals identified in paragraph (b)(1), the State must -

(1) Promptly and without undue delay, consistent with the timeliness standards established under §457.340(d) of this part, transfer the individual's electronic account to the Medicaid agency via a secure electronic interface;

(2) Include in any agreement into which the agency enters in accordance with paragraph §457.348(a) of this section, that, effective January 1, 2015, such other program will issue a combined eligibility notice, including the State's denial of CHIP eligibility;

(3) Except as provided in §457.355 of this subpart, find the individual at application ineligible, provisionally ineligible, or suspend the individual's application for CHIP unless and until the Medicaid application for the individual is denied; and

(4) Determine or redetermine eligibility for CHIP, consistent with the timeliness standards established under §457.340(d) of this part, if —

(i) The State is notified, in accordance with §435.1200(d)(5) of this chapter that the applicant has been found ineligible for Medicaid; or

(ii) The State is notified prior to the final Medicaid eligibility determination that the applicant's circumstances have changed and another screening shows that the applicant is no longer potentially eligible for Medicaid.

(g) Informed application decisions. To enable a family to make an informed decision about applying or completing the application process for Medicaid, or other insurance affordability programs, a State must provide the child's family with information, in writing, about—

(1) The State's Medicaid program and other insurance affordability programs, including the benefits covered, and restrictions on cost sharing; and

(2) Eligibility rules that prohibit children who have been screened eligible for Medicaid from being enrolled in a separate child health program, other than provisional temporary enrollment while a final Medicaid eligibility determination is being made.

(3) The State will determine the written format and timing of the information regarding Medicaid, or other insurance affordability program, eligibility, benefits, and the application processes required under this paragraph (g) of this section.

(h) Waiting lists, enrollment caps and closed enrollment. The State must establish procedures to ensure that—

(1) The procedures developed in accordance with this section have been followed for each child applying for a separate child health program before placing the child on a waiting list or otherwise deferring action on the child's application for the separate child health program; and

(2) Families are informed that a child may be eligible for Medicaid, or other insurance affordability programs, if circumstances change while the child is on a waiting list for separate child health program.

(i) Applicants found potentially eligible for other insurance affordability programs. For individuals identified in paragraph (b)(3) of this section, including during a period of uninsurance imposed by the State under §457.805 of this part, the State must –

(1) Promptly and without undue delay, consistent with the timeliness standards established under §457.340(d) of this part, transfer the electronic account to the applicable program via a secure electronic interfaces.

(2) Include in any agreement into which the agency enters in accordance with paragraph §457.348(a) of this section, that, effective January 1, 2015, such other program will issue a combined eligibility notice, including the State's denial of CHIP eligibility.

(3) In the case of individuals subject to a period of uninsurance under this part, the State must notify such program of the date on which such period ends and the individual is eligible to enroll in CHIP.

(i) Prior to January 1, 2015—

(A) Include coordinated content, as defined in §457.104 of the part, in the notice of CHIP denial or termination, provided to the individual in accordance with §457.340 of this part, relating to the transfer of the individual's account; or

(B) Include in the agreement into which the agency enters in accordance with 457.348(a) of this section, that such other program will issue a combined eligibility notice, including the State's denial of CHIP eligibility.

(ii) [Reserved]

(j) Applicants potentially eligible for Medicaid on a basis other than modified adjusted gross income. For individuals identified in paragraph (b)(2) of this section, the State must –

(1) Promptly and without undue delay, consistent with the timeliness standards established under §457.340(d) of this section, transfer the electronic account to the Medicaid agency via a secure electronic interface;

(2) Complete the determination of eligibility for CHIP in accordance with §457.340 of this part;

(3) Include in any agreement into which the agency enters in accordance with paragraph §457.348(a) of this section, that, effective January 1, 2015, such other program will issue a combined eligibility notice, including the State's denial of CHIP eligibility**.**

(i) Prior to January 1, 2015—

(A) Include coordinated content, as defined in §457.104 of the part, in the notice of CHIP denial or termination, provided to the individual in accordance with §457.340 of this part, relating to the transfer of the individual's account; or

(B) Include in the agreement into which the agency enters in accordance with 457.348(a) of this section, that such other program will issue a combined eligibility notice, including the State's denial of CHIP eligibility.

(ii) [Reserved]

(4) Dis-enroll the enrollee from CHIP if the State is notified in accordance with §435.1200(d)(5) of this chapter that the applicant has been determined eligible for Medicaid .

* * * * *

133. Section 457.351 is added to read as follows:

§457.351 Coordination involving appeals entities for different insurance affordability programs.

The State must –

(a) Establish a secure electronic interface the through which –

(1) The Exchange can notify the State that an appeal of eligibility for enrollment in a QHP through the Exchange, advance payments of the premium tax credit, or cost-sharing reductions, has been filed; and

(2) An individual's electronic account, including any information provided by the individual as part of review under subpart K of this part or an appeal to the Exchange appeals entity, can be transferred from one program or appeals entity or review body to the other.

(b) In conducting review in accordance with subpart K of this part, not request information or documentation from the individual included in the individual's electronic account or provided to the Exchange or Exchange appeals entity.

(c)(1) In the case of individuals described in paragraph (c)(2) of this section, transmit to the Exchange, through the electronic interface established under paragraph (a) of this section, a review decision issued per subpart K of this part;

(2) Individuals described in this paragraph include individuals determined ineligible for CHIP

(i) By the Exchange or

(ii) By the State and transferred to the Exchange in accordance with §457.350(i) of this part.

134. Section 457.355 is revised to read as follows:

§457.355 Presumptive eligibility for children.

The State may pay costs of coverage under a separate child health program during a presumptive eligibility period, determined in the same manner as Medicaid presumptive eligibility at §435.1102 of this chapter, for children applying for coverage under the separate child health program.

135. Section 457.360 is added to read as follows:

§457.360 Deemed newborn children.

(a) Basis. This section implements section 2112(e) of the Act.

(b) Eligibility. (1) The agency must provide CHIP to children from birth until the child's first birthday without application if—

(i) The child's mother was eligible for and received covered services for the date of the child's birth under the State's separate CHIP State plan as a targeted low-income pregnant woman in accordance with section 2112 of the Act, or at State option as a targeted low-income child; and

(ii) The child is not eligible for Medicaid under §435.117 of this chapter.

(2) The child is deemed to have applied and been determined eligible under the State's separate CHIP State plan effective as of the date of birth, and remains eligible regardless of changes in circumstances (except if the child dies or ceases to be a resident of the State or the child's representative requests a voluntary termination of the child's eligibility) until the child's first birthday.

(c) At State option, the agency may provide deemed newborn eligibility under CHIP to a child whose mother for the date of the child's birth was eligible for and receiving:

(1) CHIP coverage in another State; or

(2) Coverage under the State's demonstration under section 1115 of the Act as a Medicaid or CHIP population.

(d) CHIP identification number. (1) The CHIP identification number of the mother serves as the child's identification number, and all claims for covered services provided to the child may be submitted and paid under such number, unless and until the State issues a separate identification number for the child in accordance with paragraph (d)(2) of this section.

(2) The State must issue a separate CHIP identification number for the child prior to the effective date of any termination of the mother's CHIP eligibility or prior to the date of the child's first birthday, whichever is sooner, unless the child is determined to be ineligible, except that the State must issue a separate CHIP identification number for the child if the mother was covered in another State at the time of birth.

136. Section 457.370 is added to read as follows:

§457.370 Alignment with Exchange initial open enrollment period.

The terms of §435.1205 apply equally to the State in administering a separate CHIP, except that the State shall make available and accept the application described in §457.330 of this part, shall accept electronic accounts as described in §457.348 of this part, and furnish coverage in accordance with §457.340 of this part.

137. Section 457.380 is amended by revising paragraph (b) to read as follows:

§457.380 Eligibility verification.

* * * * *

(b) Status as a citizen or a non-citizen. (1) Except with respect to newborns identified in §435.406(a)(1)(iv) of this chapter who are exempt from any requirement to verify citizenship, States must verify citizenship or immigration status in accordance with § 435.956(a) and provide a reasonable opportunity to verify such status in accordance §435.956(g) of this chapter.

(2) [Reserved]

138. Section **§**457.570 is revised as follows:

§457.570 Disenrollment protections.

(a) The State must give enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles, or similar fees prior to disenrollment.

(b) The disenrollment process must afford the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non-payment of cost-sharing charges, and in the event that such a showing indicates that the enrollee may have become eligible for Medicaid or for a lower level of cost sharing, the State must facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate.

(c) The State must ensure that disenrollment policies, such as policies related to non-payment of premiums, do not present barriers to the timely determination of eligibility and

enrollment in coverage of an eligible child in the appropriate insurance affordability program. A State may not--

(1) Establish a premium lock-out period that exceeds 90-days in accordance with §457.10 of this part.

(2) Require the collection of past due premiums or enrollment fees as a condition of eligibility for reenrollment once the State-defined lock out period has expired, regardless of the length of the lock out period.

(d) The State must provide the enrollee with an opportunity for an impartial review to address disenrollment from the program in accordance with §457.1130(a)(3) of this part.

§457.616 [Amended]

139. Section 457.616 is amended by removing and reserving paragraph (a)(3).

140. Section 457.805 is revised to read as follows:

§457.805 State plan requirement: Procedures to address substitution under group health plans.

(a) State plan requirements. The State plan must include a description of reasonable procedures to ensure that health benefits coverage provided under the State plan does not substitute for coverage provided under group health plans as defined at §457.10 of this part.

(b) Limitations. (1) A state may not, under this section, impose a period of uninsurance which exceeds 90 days from date a child otherwise eligible for CHIP is disenrolled from coverage under a group health plan.

(2) A waiting period may not be applied to a child following the loss of eligibility for and enrollment in Medicaid or another insurance affordability program.

(3) If a state elects to impose a period of uninsurance following the loss of coverage under a group health plan under this section, such period may not be imposed in the case of any child if:

(i) The premium paid by the family for coverage of the child under the group health plan exceeded 5 percent of household income;

(ii) The cost of family coverage that includes the child exceeds 9.5 percent of the household income.

(iii) The employer stopped offering coverage of dependents (or any coverage) under an employer-sponsored health insurance plan;

(iv) A change in employment, including involuntary separation, resulted in the child's loss of employer-sponsored insurance (other than through full payment of the premium by the parent under COBRA);

(v) The child has special health care needs; and

(vi) The child lost coverage due to the death or divorce of a parent.

141. Section 457.810 is amended by revising paragraph (a) to read as follows:

§457.810 Premium assistance programs: Required protections against substitution.

*****

(a) Minimum period without coverage under a group health plan. For health benefits coverage provided through premium assistance for group health plans, the following rules apply:

(1) Any waiting period imposed under the state child health plan prior to the provision of child health assistance to a targeted low-income child under the state plan shall apply to the same extent to the provision of a premium assistance subsidy for the child.

(2) States must permit the same exemptions to the required waiting period for premium assistance as are permitted under the state plan for the provision of child health assistance to a targeted low-income child.

* * * * *

142. Section 457.1180 is revised to read as follows:

§457.1180 Program specific review process: Notice.

(a) A State must provide enrollees and applicants timely written notice of any determinations required to be subject to review under §457.1130 that includes the reasons for the determination, an explanation of the applicable rights to review of that determination, the standard and expedited time frames for review, the manner in which a review can be requested, and the circumstances under which enrollment may continue pending review. If an individual has been denied eligibility for CHIP by the State or other entity authorized to make such determination, the State must treat an appeal to the Exchange appeals entity of a determination of eligibility for advanced payments of the premium tax credit or cost-sharing reductions, as a request for a review of a denial of CHIP eligibility under this subpart.

(b) [Reserved]

For the reasons set forth in the preamble, the Department of Health and Human Services amends 45 CFR subtitle A, subchapter B, as set forth below:

PART 155 --EXCHANGE ESTABLISHMENT STANDARDS AND OTHER RELATED STANDARDS UNDER THE AFFORDABLE CARE ACT

143. The authority citation for part 155 is revised to read as follows:

Authority: Sections 1301, 1302, 1303, 1304, 1311, 1312, 1313, 1321, 1322, 1331, 1332, 1334, 1402, 1413, 1321, 1322, 1331, 1332, 1334, 1402, 1411, 1412, 1413 of the Affordable Care Act, Pub. L 111-148, 124 Stat 199.

144. Section 155.20 is amended by:

A. Revising the definitions of "Advance payments of the premium tax credit," "Application filer," and "Lawfully present"

B. Adding a new definition of "Catastrophic plan,"

The revisions and addition read as follows:

§155.20 Definitions.

* * * * *

Advance payments of the premium tax credit means payment of the tax credits authorized by 26 U.S.C. § 36B and its implementing regulations, which are provided on an advance basis to an eligible individual enrolled in a QHP through an Exchange in accordance with section 1412 of the Affordable Care Act.

* * * * *

Application filer means an applicant, an adult who is in the applicant's household, as defined in 42 CFR 435.603(f), or family, as defined in 26 CFR 1.36B-1(d); an authorized representative of an applicant; or if the applicant is a minor or incapacitated, someone acting responsibly for an applicant.

* * * * *

Catastrophic plan means a health plan described in section 1302(e) of the Affordable Care Act.

* * * * *

Lawfully present has the meaning given the term in 42 CFR 435.4.

* * * * *

145. Section 155.105 is amended by revising paragraph (b)(2) to read as follows:

§155.105 Approval of a State Exchange.

* * * * *

(b) * * *

(2) The Exchange is capable of carrying out the information reporting requirements of 26 CFR 1.36B-5;

* * * * *

146. Section 155.200 is amended by revising paragraph (a) to read as follows:

§155.200 Functions of an Exchange.

(a) General requirements. The Exchange must perform the minimum functions described in this subpart and in subparts D, E, F, H, and K of this part.

* * * * *

147. Section 155.205 is amended by revising paragraph (d) to read as follows:

§155.205 Consumer assistance tools and programs of an Exchange.

* * * * *

(d) Consumer assistance. (1) The Exchange must have a consumer assistance function that meets the standards in paragraph (c) of this section, including the Navigator program described in §155.210. Any individual providing such consumer assistance must be trained regarding QHP options, insurance affordability programs, eligibility, and benefits rules and

regulations governing all insurance affordability programs operated in the state, as implemented in the state, prior to providing such assistance.

(2) The Exchange must refer consumers to consumer assistance programs in the state when available and appropriate.

148. Section 155.225 is added to read as follows:

§155.225 Certified application counselors.

(a) General rule. The Exchange must certify staff and volunteers of Exchange-designated organizations and organizations designated by state Medicaid and CHIP agencies pursuant to 42 CFR 435.908 to act as application counselors to-

(1) Provide information about insurance affordability programs and coverage options;

(2) Assist individuals and employees to apply for coverage in a QHP through the Exchange and for insurance affordability programs; and

(3) Help to facilitate enrollment of eligible individuals in QHPs and insurance affordability programs.

(b) Standards of certification. The Exchange must certify an individual to become an application counselor if he or she:

(1) Registers with the Exchange;

(2) Is trained regarding QHP options, insurance affordability programs, eligibility, and benefits rules and regulations governing all insurance affordability programs operated in the state, as implemented in the state, prior to functioning as an application counselor;

(3) Discloses to the Exchange and potential applicants any relationships the application assister or sponsoring agency has with QHPs or insurance affordability programs, or other potential conflicts of interest;

(4) Complies with the Exchange's privacy and security standards adopted consistent with 45 CFR 155.260, and applicable authentication and data security standards;

(5) Agrees to act in the best interest of the applicants assisted;

(6) Complies with applicable state law related to application counselors, including but not limited to state law related to conflicts of interest;

(7) Provides information with reasonable accommodations for those with disabilities, as defined by the Americans with Disabilities Act, if providing in-person assistance; and

(8) Enters into an agreement with the Exchange regarding compliance with the standards specified in this paragraph.

(c) Withdrawal of certification. The Exchange must establish procedures to withdraw certification from individual application counselors, or from all application counselors associated with a particular organization, when it finds noncompliance with the terms and conditions of the application counselor agreement.

(d) Availability of information; authorization. The Exchange must establish procedures to ensure that applicants –

(1) Are informed of the functions and responsibilities of certified application counselors; and

(2) Provide authorization for the disclosure of applicant information to an application counselor prior to a counselor helping the applicant with submitting an application.

(e) Fees. Certified application counselors may not impose any charge on applicants for application assistance.

149. Section 155.227 is added to read as follows:

§155.227 Authorized representatives.

(a) General rule. (1) The Exchange must permit an individual or employee, subject to applicable privacy and security requirements, to designate an individual or organization to act on his or her behalf in applying for an eligibility determination or redetermination, under subpart D of this part, and in carrying out other ongoing communications with the Exchange.

(2) Designation of an authorized representative must be in writing, including a signature or through another legally binding format subject to applicable authentication and data security standards. If submitted, legal documentation of authority to act on behalf of an individual under state law, such as a court order establishing legal guardianship or a power of attorney for, shall serve in the place of the applicant's signature.

(3) The Exchange ensures the authorized representative agrees to maintain, or be legally bound to maintain, the confidentiality of any information regarding the individual or employee provided by the Exchange.

(4) The Exchange ensures the authorized representative is responsible for fulfilling all responsibilities encompassed within the scope of the authorized representation, as described in this section, to the same extent as the individual he or she represents.

(b) Timing of designation. The Exchange must permit an individual or employee to designate an authorized representative:

(1) At the time of application.

(2) At other times and through methods as described in 45 CFR 155.405(c)(2).

(c) Duties. The Exchange must permit an individual to authorize their representative to:

(1) Sign an application on the individual's behalf;

(2) Submit an update or respond to a redetermination for the individual in accordance with §155.330 or §155.335;

(3) Receive copies of the individual's notices and other communications from the Exchange; and

(4) Act on behalf of the individual in all other matters with the Exchange.

(d) Duration. The Exchange must consider an authorized representative valid until the applicant or enrollee:

(1) Modifies the authorization;

(2) Notifies the Exchange and the representative that the representative is no longer authorized to act on his or her behalf using one of the methods available for the submission of an application, as described in 45 CFR 155.405(c); or

(3) The authorized representative informs the Exchange and the individual that he or she no longer is acting in such capacity.

(e) Agreement. When an organization is designated as an authorized representative, staff or volunteers of that organization that exercise that capacity for an applicant before the Exchange and the organization itself must enter into an agreement with the Exchange to comply with the requirements set forth at §155.225(b).

(f) Compliance with State and federal law. The Exchange require an authorized representative to comply with applicable state and federal laws concerning conflicts of interest and confidentiality of information.

(g) Signature. For purposes of this section, designation of an authorized representative must be in writing including a signature or through another legally binding format and be accepted through all of the modalities described in 45 CFR 155.405(c) of this part.

150. Section 155.230 is amended by—

A. Revising paragraph (a).

B. Adding paragraph (d).

The revision and addition read as follows:

§155.230 General standards for Exchange notices.

(a) General requirement. Any notice required to be sent by the Exchange to individuals or employers must be written and include:

(1) An explanation of the action reflected in the notice, including the effective date of the action.

(2) Any factual findings relevant to the action.

(3) Citations to, or identification of, the relevant regulations supporting the action.

(4) Contact information for available customer service resources.

(5) An explanation of appeal rights, if applicable.

* * * * *

(d) Electronic notices. The Exchange, with the exception of the SHOP Exchange, must provide required notices either through standard mail, or if an individual or employer elects, electronically, provided that the requirements for electronic notices in 42 CFR 435.918 are met.

151. Section 155.300(a) is amended by—

A. Removing the definition of "Adoption taxpayer identification number."

B. Revising the definitions of "Minimum value," "Modified Adjusted Gross Income (MAGI)," and "Qualifying coverage in an eligible employer-sponsored plan."

The revisions read as follows:

§155.300 Definitions and general standards for eligibility determinations.

(a) * * *

Minimum value when used to describe coverage in an eligible employer-sponsored plan, means that the employer-sponsored plan meets the standards with respect to coverage of the total allowed costs of benefits set forth in 26 CFR 1.36B-2(c)(3)(vi).

Modified Adjusted Gross Income (MAGI) has the same meaning as it does in 26 CFR 1.36B-1(e)(2).

* * * * *

Qualifying coverage in an eligible employer-sponsored plan means coverage in an eligible employer-sponsored plan that meets the affordability and minimum value standards specified in 26 CFR 1.36B-2(c)(3).

* * * * *

152. Section 155.302 is amended by revising paragraphs (a)(1), (b)(4)(i)(A) and (b)(5) to read as follows:

§155.302 Options for conducting eligibility determinations.

(a) * * *

(1) Directly or through contracting arrangements in accordance with §155.110(a), provided that the standards in 42 CFR 431.10(c)(2) are met; or

* * * * *

(b) * * *

(4) * * *

(i) * * *

(A) Withdraw his or her application for Medicaid and CHIP, unless the Exchange has assessed the applicant as potentially eligible for Medicaid based on factors not otherwise considered in this subpart, in accordance with §155.345(b), and provided that the application will not be considered withdrawn if he or she appeals his or her eligibility determination for advance payments of the premium tax credit or cost-sharing reductions and the appeals entity described in §155.500(a) finds that the individual is potentially eligible for Medicaid or CHIP; or

* * * * *

(5) The Exchange adheres to the eligibility determination or appeals decision for Medicaid or CHIP made by the State Medicaid or CHIP agency, or the appeals entity for such agency.

* * * * *

153. Section 155.305 is amended by—

A. Revising paragraphs (f)(1)(i), (f)(1)(ii)(B), (f)(2)(ii), (f)(2)(iii), (f)(3), and (f)(5).

B. Adding paragraphs (a)(3)(v), and (h).

The revisions and additions read as follows:

§155.305 Eligibility standards.

(a) * * * *

(3) * * * *

(v) Temporary absence. The Exchange may not deny or terminate an individual's eligibility for enrollment in a QHP through the Exchange if the individual meets the standards in paragraph (a)(3) of this section but for a temporary absence from the service area of the Exchange and intends to return when the purpose of the absence has been accomplished, unless another Exchange verifies that the individual meets the residency standard of such Exchange.

* * * * *

(f) * * *

(1) * * *

(i) He or she is expected to have a household income, as defined in 26 CFR 1.36B-1(e), of greater than or equal to 100 percent but not more than 400 percent of the FPL for the benefit year for which coverage is requested; and

(ii) * * *

(B) Is not eligible for minimum essential coverage, with the exception of coverage in the individual market, in accordance with section 26 CFR 1.36B-2(a)(2) and (c).

(2) * * *

(ii) He or she is expected to have a household income, as defined in 26 CFR 1.36B-1(e) of less than 100 percent of the FPL for the benefit year for which coverage is requested; and

(iii) One or more applicants for whom the tax filer expects to claim a personal exemption deduction on his or her tax return for the benefit year, including the tax filer and his or her spouse, is a non-citizen who is lawfully present and ineligible for Medicaid by reason of immigration status, in accordance with 26 CFR 1.36B-2(b)(5).

(3) Enrollment required. The Exchange may provide advance payments of the premium tax credit on behalf of a tax filer only if one or more applicants for whom the tax filer attests that he or she expects to claim a personal exemption deduction for the benefit year, including the tax filer and his or her spouse, is enrolled in a QHP that is not a catastrophic plan, through the Exchange.

* * * * *

(5) Calculation of advance payments of the premium tax credit. The Exchange must calculate advance payments of the premium tax credit in accordance with 26 CFR 1.36B-3.

* * * * *

(h) Eligibility for enrollment through the Exchange in a QHP that is a catastrophic plan. The Exchange must determine an applicant eligible for enrollment in a QHP through the Exchange in a QHP that is a catastrophic plan as defined by section 1302(e) of the Affordable Care Act, if he or she--

(1) Has not attained the age of 30 before the beginning of the plan year; or

(2) Has a certification in effect for any plan year that he or she is exempt from the requirement to maintain minimum essential coverage under section 5000A of the Code by reason of --

(i) Section 5000A(e)(1) of the Code (relating to individuals without affordable coverage); or

(ii) Section 5000A(e)(5) of the Code (relating to individuals with hardships).

154. Section 155.310 is amended by—

A. Redesignating paragraph (i) as paragraph (j).

B. Adding new paragraph (i).

C. Revising newly redesignated paragraph (j).

The addition reads as follows:

§155.310 Eligibility process.

* * * * *

(i) Certification program for employers. As part of its determination of whether an employer has a liability under section 4980H of the Code, the Internal Revenue Service will adopt methods to certify to an employer that one or more employees has enrolled for one or more months during a year in a QHP with respect to which a premium tax credit or cost-sharing reduction is allowed or paid.

(j) Duration of eligibility determinations without enrollment. To the extent that an applicant who is determined eligible for enrollment in a QHP does not select a QHP within his or her enrollment period, or is not eligible for an enrollment period, in accordance with subpart E, and seeks a new enrollment period prior to the date on which his or her eligibility is redetermined in accordance with §155.335 the Exchange must require the applicant to attest as to whether information affecting his or her eligibility has changed since his or her most recent eligibility determination before determining his or her eligibility for a special enrollment period, and must process any changes reported in accordance with the procedures specified in §155.330.

155. Section 155.315 is amended by—

A. Revising paragraph (b)(2), paragraph (f) introductory text, and paragraph (f)(4).

B. Adding paragraph (j).

The revisions and addition read as follows:

§155.315 Verification process related to eligibility for enrollment in a QHP through the Exchange.

* * * * *

(b) * * *

(2) To the extent that the Exchange is unable to validate an individual's Social Security number through the Social Security Administration, or the Social Security Administration

indicates that the individual is deceased, the Exchange must follow the procedures specified in paragraph (f) of this section, except that the Exchange must provide the individual with a period of 90 days from the date on which the notice described in paragraph (f)(2)(i) of this section is received for the applicant to provide satisfactory documentary evidence or resolve the inconsistency with the Social Security Administration. The date on which the notice is received means 5 days after the date on the notice, unless the individual demonstrates that he or she did not receive the notice within the 5 day period.

* * * * *

(f) Inconsistencies. Except as otherwise specified in this subpart, for an applicant for whom the Exchange cannot verify information required to determine eligibility for enrollment in a QHP through the Exchange, advance payments of the premium tax credit, and cost-sharing reductions, including when electronic data is required in accordance with this subpart but data for individuals relevant to the eligibility determination are not included in such data sources or when electronic data is required but it is not reasonably expected that data sources will be available within 2 days of the initial request to the data source, the Exchange:

* * * * *

(4) During the periods described in paragraphs (f)(1) and (f)(2)(ii) of this section, must:

* * * * *

(j) Verification related to eligibility for enrollment through the Exchange in a QHP that is a catastrophic plan. The Exchange must verify an applicant's attestation that he or she meets the requirements of §155.305(h) by –

(1) Verifying the applicant's attestation of age as follows –

(i) Except as provided in paragraph (j)(1)(iii) of this section, accepting his or her attestation without further verification; or

(ii) Examining electronic data sources that are available to the Exchange and which have been approved by HHS for this purpose, based on evidence showing that such data sources are sufficiently current and accurate, and minimize administrative costs and burdens.

(iii) If information regarding age is not reasonably compatible with other information provided by the individual or in the records of the Exchange, the Exchange must examine information in data sources that are available to the Exchange and which have been approved by HHS for this purpose based on evidence showing that such data sources are sufficiently current and accurate.

(2) Verifying that an applicant has received a certificate of exemption as described in §155.305(h)(2).

(3) To the extent that the Exchange is unable to verify the information required to determine eligibility for enrollment through the Exchange in a QHP that is a catastrophic plan as described in paragraphs (j)(1) and (j)(2) of this section, the Exchange must follow the procedures specified in §155.315(f), except for §155.315(f)(4).

156. Section 155.320 is amended by—

A. Revising the introductory text of paragraph (c)(1)(i).

B. Revising paragraphs (c)(1)(i)(A), (c)(1)(ii), (c)(3)(i)(D), (c)(3)(ii)(A), (c)(3)(iii)(A) and (B), (c)(3)(vi), (c)(3)(vii), (c)(3)(viii), and (d).

C. Adding paragraphs (c)(3)(i)(E) and (c)(3)(iii)(C).

D. Removing paragraph (e).

E. Redesignating paragraph (f) as paragraph (e).

The revisions and additions read as follows:

§155.320 Verification process related to eligibility for insurance affordability programs.

* * * * *

(c) * * *

(1) * * *

(i) Data regarding annual household income.

(A) For all individuals whose income is counted in calculating a tax filer's household income, as defined in 26 CFR 1.36B-1(e), or an applicant's household income, calculated in accordance with 42 CFR 435.603(d), and for whom the Exchange has a Social Security number , the Exchange must request tax return data regarding MAGI and family size from the Secretary of the Treasury and data regarding Social security benefits described in 26 CFR 1.36B-1(e)(2)(iii) from the Commissioner of Social Security by transmitting identifying information specified by HHS to HHS.

* * * * *

(ii) Data regarding MAGI-based income. For all individuals whose income is counted in calculating a tax filer's household income, as defined in 26 CFR 1.36B-1(e), or an applicant's household income, calculated in accordance with 42 CFR 435.603(d), the Exchange must request data regarding MAGI-based income in accordance with 42 CFR 435.948(a).

* * * * *

(3) * * *

(i) * * *

(D) If the Exchange finds that an applicant's attestation of a tax filer's family size is not reasonably compatible with other information provided by the application filer for the family or in the records of the Exchange, with the exception of the data described in paragraph (c)(1)(i) of this section, the Exchange must utilize data obtained through other electronic data sources to verify the attestation. If such data sources are unavailable or information in such data sources is not reasonably compatible with the applicant's attestation, the Exchange must request additional documentation to support the attestation within the procedures specified in §155.315(f) of this part.

(E) The Exchange must verify that neither advance payments of the premium tax credit nor cost-sharing reductions are being provided on behalf of an individual using information obtained by transmitting identifying information specified by HHS to HHS.

* * * * *

(ii) * * * * *

(A) The Exchange must compute annual household income for the family described in paragraph (c)(3)(i)(A) of this section based on the data described in paragraph (c)(1)(i) of this section;

* * * * *

(iii) * * *

(A) Except as specified in paragraph (c)(3)(iii)(B) and (C) of this section, if an applicant's attestation, in accordance with paragraph (c)(3)(ii)(B) of this section, indicates that a tax filer's annual household income has increased or is reasonably expected to increase from the data described in paragraph (c)(3)(ii)(A) of this section for the benefit year for which the applicant(s) in the tax filer's family are requesting coverage and the Exchange has not verified the applicant's MAGI-based income through the process specified in paragraph (c)(2)(ii) of this section to be within the applicable Medicaid or CHIP MAGI-based income standard, the Exchange must accept the applicant's attestation regarding a tax filer's annual household income without further verification.

(B) If data available to the Exchange in accordance with paragraph (c)(1)(ii) of this section indicate that a tax filer's projected annual household income is in excess of his or her attestation by a significant amount, the Exchange must proceed in accordance with §155.315(f)(1) through (4) of this part.

(C) If other information provided by the application filer indicates that a tax filer's projected annual household income is in excess of his or her attestation by a significant amount,

the Exchange must utilize data available to the Exchange in accordance with paragraph (c)(1)(ii) of this section to verify the attestation. If such data is unavailable or are not reasonably compatible with the applicant's attestation, the Exchange must proceed in accordance with §155.315(f)(1) through (4) of this part.

(vi) Alternate verification process for decreases in annual household income and situations in which tax return data is unavailable. If a tax filer qualifies for an alternate verification process based on the requirements specified in paragraph (c)(3)(iv) of this section and the applicant's attestation to projected annual household income, as described in paragraph (c)(3)(ii)(B) of this section, is greater than ten percent below the annual household income computed in accordance with paragraph (c)(3)(ii)(A), or if data described in paragraph (c)(1)(i) of this section is unavailable, the Exchange must attempt to verify the applicant's attestation of the tax filer's projected annual household income by following the procedures specified in paragraph (c)(3)(vi)(A) through (G).

(A) Data. The Exchange must annualize data from the MAGI-based income sources specified in paragraph (c)(1)(ii) of this section, and obtain any data available from other electronic data sources that have been approved by HHS, based on evidence showing that such data sources are sufficiently accurate and offer less administrative complexity than paper verification.

(B) To the extent that the applicant's attestation indicates that the information described in paragraph (c)(3)(vi)(A) of this section represents an accurate projection of the tax filer's household income for the benefit year for which coverage is requested, the Exchange must determine the tax filer's eligibility for advance payments of the premium tax credit and cost-sharing reductions based on the household income data in paragraph (c)(3)(vi)(A) of this section.

(C) Increases in annual household income. If an applicant's attestation, in accordance with paragraph (c)(3)(ii)(B) of this section, indicates that a tax filer's annual household income

has increased or is reasonably expected to increase from the data described in paragraph (c)(3)(vi)(A) of this section to the benefit year for which the applicant(s) in the tax filer's family are requesting coverage and the Exchange has not verified the applicant's MAGI-based income through the process specified in paragraph (c)(2)(ii) of this section to be within the applicable Medicaid or CHIP MAGI-based income standard, the Exchange must accept the applicant's attestation for the tax filer's family without further verification, unless the Exchange finds that an applicant's attestation of a tax filer's annual household income is not reasonably compatible with other information provided by the application filer or available to the Exchange in accordance with paragraph (c)(1)(ii) of this section, in which case the Exchange must request additional documentation using the procedures specified in §155.315(f).

(D) Decreases in annual household income and situations in which electronic data is unavailable. If electronic data are unavailable or an applicant's attestation to projected annual household income, as described in paragraph (c)(3)(ii)(B) of this section, is more than ten percent below the annual household income as computed using data sources described in paragraphs (c)(3)(vi)(A) of this section, the Exchange must follow the procedures specified in §155.315(f)(1) through (4).

(E) If, following the 90-day period described in paragraph (c)(3)(vi)(D) of this section, an applicant has not responded to a request for additional information from the Exchange and the data sources specified in paragraph (c)(1) of this section indicate that an applicant in the tax filer's family is eligible for Medicaid or CHIP, the Exchange must not provide the applicant with eligibility for advance payments of the premium tax credit, cost-sharing reductions, Medicaid, CHIP or the BHP, if a BHP is operating in the service area of the Exchange.

(F) If, at the conclusion of the period specified in paragraph (c)(3)(vi)(D) of this section, the Exchange remains unable to verify the applicant's attestation, the Exchange must determine the applicant's eligibility based on the information described in paragraph (c)(3)(ii)(A) of this

section, notify the applicant of such determination in accordance with the notice requirements specified in §155.310(g), and implement such determination in accordance with the effective dates specified in §155.330(f).

(G) If, at the conclusion of the period specified in paragraph (c)(3)(vi)(D) of this section, the Exchange remains unable to verify the applicant's attestation for the tax filer and the information described in paragraph (c)(3)(ii)(A) of this section is unavailable, the Exchange must determine the tax filer ineligible for advance payments of the premium tax credit and cost-sharing reductions, notify the applicant of such determination in accordance with the notice requirement specified in §155.310(g), and discontinue any advance payments of the premium tax credit and cost-sharing reductions in accordance with the effective dates specified in §155.330(f).

(vii) For the purposes of paragraph (c)(3) of this section, "household income" means household income as specified in 26 CFR 1.36B-1(e).

(viii) For the purposes of paragraph (c)(3) of this section, "family size" means family size as specified in 26 CFR 1.36B-1(d).

(d) Verification related to enrollment in an eligible employer-sponsored plan and eligibility for qualifying coverage in an eligible employer-sponsored plan.

(1) General requirement. The Exchange must verify whether an applicant reasonably expects to be enrolled in an eligible employer-sponsored plan or is eligible for qualifying coverage in an eligible employer-sponsored plan for the benefit year for which coverage is requested.

(2) Data. The Exchange must –

(i) Obtain data about enrollment in and eligibility for an eligible employer-sponsored plan from any electronic data sources that are available to the Exchange and which have been approved by HHS, based on evidence showing that such data sources are sufficiently current,

accurate, and minimize administrative burden.

(ii) Obtain any available data regarding enrollment in employer-sponsored coverage or eligibility for qualifying coverage in an eligible employer-sponsored plan based on federal employment by transmitting identifying information specified by HHS to HHS.

(iii) Obtain data from the SHOP that corresponds to the State in which the Exchange is operating.

(iv) Obtain any available data regarding the employment of an applicant and the members of his or her household, as defined in 26 CFR 1.36B-1(d), from any electronic data sources that are available to the Exchange and have been approved by HHS for this purpose, based on evidence showing that such data sources are sufficiently current, accurate, and minimize administrative burden.

(3) Verification procedures. (i) Except as specified in paragraphs (d)(3)(ii) or (iii) of this section, the Exchange must accept an applicant's attestation regarding the verification specified in paragraph (d) without further verification.

(ii) If an applicant's attestation is not reasonably compatible with the information specified in paragraphs (d)(2)(i) through (d)(2)(iii) of this section, other information provided by the application filer, or other information in the records of the Exchange, the Exchange must follow the procedures specified in §155.315(f) of this subpart.

(iii) If the Exchange does not have any of the information specified in paragraphs (d)(2)(i) through (d)(2)(iii) for an applicant, and either does not have the information specified in paragraph (d)(2)(iv) for an applicant or an applicant's attestation is not reasonably compatible with the information specified in (d)(2)(iv) of this section, the Exchange must select a statistically significant random sample of such applicants and –

(A) Provide notice to the applicant indicating that the Exchange will be contacting any employer identified on the application for the applicant and the members of his or her household,

as defined in 26 CFR 1.36B-1(d), to verify whether the applicant is enrolled in an eligible employer-sponsored plan or is eligible for qualifying coverage in an eligible employer-sponsored plan for the benefit year for which coverage is requested;

(B) Proceed with all other elements of eligibility determination using the applicant's attestation, and provide eligibility for enrollment in a QHP to the extent that an applicant is otherwise qualified;

(C) Ensure that advance payments of the premium tax credit and cost-sharing reductions are provided on behalf of an applicant who is otherwise qualified for such payments and reductions, as described in §155.305 of this subpart, if the tax filer attests to the Exchange that he or she understands that any advance payments of the premium tax credit paid on his or her behalf are subject to reconciliation;

(D) Make reasonable attempts to contact any employer identified on the application for the applicant and the members of his or her household, as defined in 26 CFR 1.36B-1(d), to verify whether the applicant is enrolled in an eligible employer-sponsored plan or is eligible for qualifying coverage in an eligible employer-sponsored plan for the benefit year for which coverage is requested;

(E) If the Exchange receives any information from an employer relevant to the applicant's enrollment in an eligible employer-sponsored plan or eligibility for qualifying coverage in an eligible employer-sponsored plan, the Exchange must determine the applicant's eligibility based on such information and in accordance with the effective dates specified in 155.330(f) of this subpart, and if such information changes his or her eligibility determination, notify the applicant and his or her employer or employers of such determination in accordance with the notice requirements specified in §155.310(g) and (h) of this part;

(F) If, after a period of 90 days from the date on which the notice described in paragraph (d)(3)(iii)(A) of this section is sent to the applicant, the Exchange is unable to obtain the

necessary information from an employer, the Exchange must determine the applicant's eligibility based on his or her attestation regarding that employer.

(G) In order to carry out the process described in paragraph (d)(3)(iii) of this section, the Exchange must only disclose an individual's information to an employer to the extent necessary for the employer to identify the employee.

(4) Option to rely on verification performed by HHS. The Exchange may satisfy the provisions of this paragraph by relying on a verification process performed by HHS, provided that –

(i) The Exchange sends the notices described in §155.310(g) and (h) of this part;

(ii) Other activities required in connection with the verifications described in this paragraph are performed by the Exchange in accordance with the standards identified in this subpart or by HHS in accordance with the agreement described in paragraph (d)(4)(iv) of this section;

(iii) The Exchange provides all relevant application information to HHS through a secure, electronic interface, promptly and without undue delay; and

(iv) The Exchange and HHS enter into an agreement specifying their respective responsibilities in connection with the verifications described in this paragraph.

* * * * *

157. Section 155.330 is amended by—

A. Revising paragraphs (d)(1)(ii), (e)(2), (f).

D. Removing paragraph (e)(3).

The revisions and additions read as follows:

§155.330 Eligibility redetermination during a benefit year.

* * * * *

(d) * * *

(1) * * *

(ii) For an enrollee on whose behalf advance payments of the premium tax credit or cost-sharing reductions are being provided, eligibility determinations for Medicare, Medicaid, CHIP, or the BHP, if a BHP is operating in the service area of the Exchange.

* * * * *

(e) * * *

(2) Data matching.

(i) If the Exchange identifies updated information regarding death, in accordance with paragraph (d)(1)(i) of this section, or regarding any factor of eligibility not regarding income, family size, or family composition, the Exchange must –

(A) Notify the enrollee regarding the updated information, as well as the enrollee's projected eligibility determination after considering such information.

(B) Allow an enrollee 30 days from the date of the notice to notify the Exchange that such information is inaccurate.

(C) If the enrollee responds contesting the updated information, proceed in accordance with §155.315(f) of this part.

(D) If the enrollee does not respond within the 30-day period specified in paragraph (e)(2)(i)(B) proceed in accordance with paragraphs (e)(1)(i) and (ii) of this section.

(ii) If the Exchange identifies updated information regarding income, family size, or family composition, with the exception of information regarding death, the Exchange must –

(A) Follow procedures described in paragraph (e)(2)(i)(A) and (B) of this section; and

(B) If the enrollee responds confirming the updated information, proceed in accordance with paragraphs (e)(1)(i) and (ii) of this section.

(C) If the enrollee does not respond within the 30-day period specified in paragraph (e)(2)(i)(B) of this section, maintain the enrollee's existing eligibility determination without

considering the updated information.

(D) If the enrollee provides more up-to-date information, proceed in accordance with paragraph (c)(1) of this section.

* * * * *

(f) Effective dates. (1) Except as specified in paragraphs (f)(2) through (f)(7) of this section, the Exchange must implement changes—

(i) Resulting from a redetermination under this section on the first day of the month following the date of the notice described in paragraph (e)(1)(ii) of this section; or

(ii) Resulting from an appeal decision, on the first day of the month following the date of the notices described in §§155.545(b) and 155.555(k), or on the date specified in the appeal decision pursuant to §155.545(c)(1), as applicable; or

(iii) Affecting enrollment or premiums only, on the first day of the month following the date on which the Exchange is notified of the change;

(2) Except as specified in paragraphs (f)(3) through (f)(7) of this section, the Exchange may determine a reasonable point in a month after which a change described in paragraph (f)(1) of this section will not be effective until the first day of the month after the month specified in paragraph (f)(1) of this section. Such reasonable point in a month must be no earlier than the 15th of the month.

(3) Except as specified in paragraphs (f)(6) and (f)(7) of this section, the Exchange must implement a change described in paragraph (f)(1) of this section that results in a decreased amount of advance payments of the premium tax credit or level of cost-sharing reductions, and for which the date of the notices described in paragraphs (f)(1)(i) and (ii) of this section, or the date on which the Exchange is notified in accordance with paragraph (f)(1)(iii) of this section is after the 15th of the month, on the first day of the month after the month specified in paragraph

(f)(1) of this section.

(4) Except as specified in paragraph (f)(6) of this section, the Exchange must implement a change described in paragraph (f)(1) of this section that results in an increased level of cost-sharing reductions, including when an individual becomes newly eligible for cost-sharing reductions, and for which the date of the notices described in paragraphs (f)(1)(i) and (ii) of this section, or the date on which the Exchange is notified in accordance with paragraph (f)(1)(iii) of this section is after the 15th of the month, on the first day of the month after the month specified in paragraph (f)(1) of this section.

(5) The Exchange must implement a change associated with the events described in §155.420(b)(2)(i) and (ii) of this part on the coverage effective dates described in §155.420(b)(2)(i) and (ii) of this part respectively, and ensure that advance payments of the premium tax credit and cost-sharing reductions are effective on the first day of the month following such events, unless the event occurs on the first day of the month.

(6) Notwithstanding paragraphs (f)(1) through (f)(5) of this section, the Exchange may provide the effective date of a change associated with the events described in §155.420(d)(4), (d)(5) of this part, and (d)(9) based on the specific circumstances of each situation.

(7) Notwithstanding paragraphs (f)(1) through (f)(6) of this section, when a change described in paragraph (f)(1) results in an enrollee being ineligible to continue his or her enrollment in a QHP through the Exchange, the Exchange must maintain his or her eligibility for enrollment in a QHP without advance payments of the premium tax credit and cost-sharing reductions, in accordance with the effective dates described in §155.430(d)(3) of this part.

158. Section 155.335 is amended by—

A. Revising paragraphs (a), (b), (c), (e), (f), (g), (h), (k)(1), and (l).

B. Adding paragraph (m).

The revisions and addition read as follows:

§155.335 Annual eligibility redetermination.

(a) General requirement. Except as specified in paragraphs (l) and (m) of this section, the Exchange must redetermine the eligibility of a qualified individual on an annual basis.

(b) Updated income and family size information. In the case of a qualified individual who requested an eligibility determination for insurance affordability programs in accordance with §155.310(b) of this part, the Exchange must request updated tax return information, if the qualified individual has authorized the request of such tax return information, data regarding Social Security benefits, and data regarding MAGI-based income as described in §155.320(c)(1) of this part for use in the qualified individual's eligibility redetermination.

(c) Notice to qualified individual. The Exchange must provide a qualified individual with an annual redetermination notice including the following:

(1) The data obtained under paragraph (b) of this section, if applicable.

(2) The data used in the qualified individual's most recent eligibility determination.

(3) The qualified individual's projected eligibility determination for the following year, after considering any updated information described in paragraph (c)(1) of this section, including, if applicable, the amount of any advance payments of the premium tax credit and the level of any cost-sharing reductions or eligibility for Medicaid, CHIP or BHP.

* * * * *

(e) Changes reported by qualified individuals. (1) The Exchange must require a qualified individual to report any changes with respect to the information listed in the notice described in paragraph (c) of this section within 30 days from the date of the notice.

(2) The Exchange must allow a qualified individual, or an application filer, on behalf of the qualified individual, to report changes via the channels available for the submission of an application, as described in §155.405(c)(2) .

(f) Verification of reported changes. The Exchange must verify any information reported

by a qualified individual under paragraph (e) of this section using the processes specified in §155.315 and §155.320, including the relevant provisions in those sections regarding inconsistencies, prior to using such information to determine eligibility.

(g) Response to redetermination notice. (1) The Exchange must require a qualified individual, or an application filer, on behalf of the qualified individual, to sign and return the notice described in paragraph (c) of this section.

(2) To the extent that a qualified individual does not sign and return the notice described in paragraph (c) of this section within the 30-day period specified in paragraph (e) of this section, the Exchange must proceed in accordance with the procedures specified in paragraph (h)(1) of this section.

(h) Redetermination and notification of eligibility. (1) After the 30-day period specified in paragraph (e) of this section has elapsed, the Exchange must—

(i) Redetermine the qualified individual's eligibility in accordance with the standards specified in §155.305 using the information provided to the qualified individual in the notice specified in paragraph (c) of this section, as supplemented with any information reported by the qualified individual and verified by the Exchange in accordance with paragraphs (e) and (f) of this section.

(ii) Notify the qualified individual in accordance with the requirements specified in §155.310(g).

(iii) If applicable, notify the qualified individual employer, in accordance with the requirements specified in §155.310(h).

(2) If a qualified individual reports a change with respect to the information provided in the notice specified in paragraph (c) of this section that the Exchange has not verified as of the end of the 30-day period specified in paragraph (e) of this section, the Exchange must redetermine the qualified individual's eligibility after completing verification, as specified in

paragraph (f) of this section.

* * * * *

(k) Authorization of the release of tax data to support annual redetermination. (1) The Exchange must have authorization from a qualified individual to obtain updated tax return information described in paragraph (b) of this section for purposes of conducting an annual redetermination.

* * * * *

(l) Limitation on redetermination. To the extent that a qualified individual has requested an eligibility determination for insurance affordability programs in accordance with §155.310(b) and the Exchange does not have an active authorization to obtain tax data as a part of the annual redetermination process, the Exchange must redetermine the qualified individual's eligibility only for enrollment in a QHP and notify the enrollee in accordance with the timing described in paragraph (d) of this section. The Exchange may not proceed with a redetermination for insurance affordability programs until such authorization has been obtained or the qualified individual continues his or her request for an eligibility determination for insurance affordability programs in accordance with §155.310(b).

(m) Special rule. The Exchange must not redetermine a qualified individual's eligibility in accordance with this section if the qualified individual's eligibility was redetermined under this section during the prior year, and the qualified individual was not enrolled in a QHP through the Exchange at the time of such redetermination, and has not enrolled in a QHP through the Exchange since such redetermination.

159. Section 155.340 is amended by revising paragraphs (b) introductory text, (b)(1) and (c) to read as follows:

§155.340 Administration of advance payments of the premium tax credit and cost-sharing reductions.

* * * * *

(b) Requirement to provide information related to employer responsibility. (1) In the event that the Exchange determines that an individual is eligible for advance payments of the premium tax credit or cost-sharing reductions based in part on a finding that an individual's employer does not provide minimum essential coverage, or provides minimum essential coverage that is unaffordable, within the standard of 26 CFR 1.36B-2(c)(3)(v)(A)(1), or provide minimum essential coverage that does not meet the minimum value standard of 26 CFR 1.36B-2(c)(3)(vi), the Exchange must transmit the individual's name and taxpayer identification number to HHS.

* * * * *

(c) Requirement to provide information related to reconciliation of advance payments of the premium tax credit. The Exchange must comply with the requirements of 26 CFR 1.36B-5 regarding reporting to the IRS and to taxpayers.

* * * * *

160. Section 155.345 is amended by—

A. Revising paragraphs (a) introductory text, (a)(2), (f), (g) introductory text and (g)(2) through (g)(5).

B. Redesignating paragraph (a)(3) as paragraph (a)(5).

C. Adding new paragraphs (a)(3), (a)(4), (g)(6), (g)(7).

The revisions and addition read as follows:

§155.345 Coordination with Medicaid, CHIP, the basic Health Program, and the Pre-existing Condition Insurance Plan.

(a) Agreements. The Exchange must enter into agreements with agencies administering Medicaid, CHIP, and the BHP, if a BHP is operating in the service area of the Exchange, as are necessary to fulfill the requirements of this subpart and provide copies of any such agreements to HHS upon request. Such agreements must include a clear delineation of the responsibilities of each agency to –

* * * * *

(2) Ensure prompt determinations of eligibility and enrollment in the appropriate program without undue delay, based on the date the application is submitted to or redetermination is initiated by the Exchange or the agency administering Medicaid, CHIP, or the BHP;

(3) Notices. (i) Prior to January 1, 2015, include coordinated content, as defined in 42 CFR 435.4, in the notice of eligibility determination provided to the individual in accordance with §155.310(g) of this part;

(ii) As of January 1, 2015 and to the extent feasible, provide for a combined eligibility notice, as defined in 42 CFR 435.4 and which meets the requirements of §155.230(a) and (b), promptly and without undue delay, to an applicant and the members of his or her household, as defined in 42 CFR 435.603(f) and 26 CFR 1.36B-1(d), who apply together, for enrollment in a qualified health plan through the Exchange and for all insurance affordability programs. To the extent appropriate, such a notice will be issued by the last agency to determine the individual's eligibility except for eligibility for Medicaid based on standards other than those specified in §155.305(c), regardless of which agency receives the application, and must specify the agency which actually made each included eligibility determination.

(4) Ensure compliance with paragraphs (c), (d), (e), and (g) of this section.

* * * * *

(f) Special rule. If the Exchange verifies that a tax filer's household income, as defined in 26 CFR 1.36B-1(e), is less than 100 percent of the FPL for the benefit year for which coverage is requested, determines that the tax filer is not eligible for advance payments of the premium tax credit based on §155.305(f)(2), and one or more applicants in the tax filer's household has been determined ineligible for Medicaid and CHIP based on income, the Exchange must –

* * * * *

(g) Determination of eligibility for individuals submitting applications directly to an agency administering Medicaid, CHIP, or the BHP. The Exchange, in consultation with the agency or agencies administering Medicaid, CHIP, and the BHP if a BHP is operating in the service area of the Exchange, must establish procedures to ensure that an eligibility determination for enrollment in a QHP, advance payments of the premium tax credit, and cost-sharing reductions is performed when an application is submitted directly to an agency administering Medicaid, CHIP, or the BHP if a BHP is operating in the service area of the Exchange. Under such procedures, the Exchange must—

* * * * *

(2) Notify such agency of the receipt of the information described in paragraph (g)(1) of this section and final eligibility determination for enrollment in a QHP, advance payments of the premium tax credit, and cost-sharing reductions;

(3) Not duplicate any eligibility and verification findings already made by the transmitting agency, to the extent such findings are made in accordance with this subpart;

(4) Not request information or documentation from the individual already provided to another agency administering an insurance affordability program and included in the transmission of information provided on the application or other information transmitted from the other agency;

(5) Determine the individual's eligibility for enrollment in a QHP, advance payments of the premium tax credit, and cost-sharing reductions, promptly and without undue delay, and in accordance with this subpart;

(6) Follow a streamlined process for eligibility determinations regardless of the agency that initially received an application; and

(7) Effective January 1, 2015, provide a combined eligibility notice, as defined in 42 CFR 435.4, for eligibility determinations for enrollment in a QHP and for insurance affordability programs, except for eligibility for Medicaid based on standards other than those specified in §155.305(c), when another agency administering an insurance affordability program transfers the information described in paragraph (g)(1) of this section to the Exchange.

* * * * *

161. Section 155.350 is amended by revising paragraph (a)(1)(ii) to read as follows:

§155.350 Special eligibility standards and process for Indians.

(a) * * *

(1) * * *

(ii) Is expected to have a household income, as defined in 26 CFR 1.36B-1(e) that does not exceed 300 percent of the FPL for the benefit year for which coverage is requested.

* * * * *

162. Section 155.400 is amended by adding paragraph (b)(3) to read as follows:

§155.400 Enrollment of qualified individuals into QHPs.

* * * * *

(b)* * *

(3) Send updated eligibility and enrollment information to HHS promptly and without undue delay, in a manner and timeframe as specified by HHS.

* * * * *

163. Section 155.420 is amended by—

A. Revising paragraphs (a), (b)(2), (b)(3), and (d)(1) through (d)(9)

B. Adding paragraphs (b)(4) and (d)(10).

The revisions and additions read as follows:

§155.420 Special enrollment periods.

* * * * *

(a) General requirements. (1) The Exchange must provide special enrollment periods consistent with this section, during which qualified individuals may enroll in QHPs and enrollees may change QHPs.

(2) For the purpose of this section, "dependent", has the same meaning as it does in 26 CFR 54.9801-2, referring to any individual who is or who may become eligible for coverage under the terms of a QHP because of a relationship to a qualified individual or enrollee.

(b)* * *

(2) Special effective dates. (i) In the case of birth, adoption, or placement for adoption, the Exchange must ensure that coverage is effective for a qualified individual or enrollee on the date of birth, adoption, or placement for adoption.

(ii) In the case of marriage, or in the case where a qualified individual loses minimum essential coverage, as described in paragraph (d)(1) of this section, the Exchange must ensure that coverage is effective for a qualified individual or enrollee on the first day of the following month.

(iii) In the case of a qualified individual or enrollee eligible for a special enrollment period as described in paragraphs (d)(4), (d)(5), or (d)(9) of this section, the Exchange must ensure that coverage is effective on an appropriate date based on the circumstances of the special enrollment period, in accordance with guidelines issued by HHS. Such date much be either—

(A) The date of the event that triggered the special enrollment period under (d)(4), (d)(5),

or (d)(9) of this section; or

(B) In accordance with the regular effective dates specified in paragraph (b)(1) of this section.

(3) Option for earlier effective dates. Subject to the Exchange demonstrating to HHS that all of its participating QHP issuers agree to effectuate coverage in a timeframe shorter than discussed in paragraph (b)(1) or (b)(2)(ii) of this section, the Exchange may do one or both of the following for all applicable individuals:

(i) For a QHP selection received by the Exchange from a qualified individual in accordance with the dates specified in paragraph (b)(1) or (b)(2)(ii) of this section, the Exchange may provide a coverage effective date for a qualified individual earlier than specified in such paragraphs.

(ii) For a QHP selection received by the Exchange from a qualified individual on a date set by the Exchange after the fifteenth of the month, the Exchange may provide a coverage effective date of the first of the following month.

(4) Advance payments of the premium tax credit and cost-sharing reductions. Notwithstanding the standards of this section, the Exchange must ensure that advance payments of the premium tax credit and cost-sharing reductions adhere to the effective dates specified in §155.330(f).

* * * * *

(d) The Exchange must allow a qualified individual or enrollee, and, when specified below, his or her dependent, to enroll in or change from one QHP to another if one of the following triggering events occur:

(1) The qualified individual or his or her dependent loses minimum essential coverage:

(i) In the case of a QHP decertification, the triggering event is the date of the notice of decertification as described in §155.1080(e)(2); or

(ii) In all other cases, the triggering event is the date the individual or dependent loses eligibility for minimum essential coverage;

(2) The qualified individual gains a dependent or becomes a dependent through marriage, birth, adoption or placement for adoption;

(3) The qualified individual, who was not previously a citizen, national, or lawfully present individual gains such status;

(4) The qualified individual's or his or her dependent's, enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Exchange or HHS, or its instrumentalities as evaluated and determined by the Exchange. In such cases, the Exchange may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction;

(5) The enrollee or, his or her dependent adequately demonstrates to the Exchange that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee;

(6) Newly eligible or ineligible for advance payments of the premium tax credit, or change in eligibility for cost-sharing reductions. (i) The enrollee is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions;

(ii) The enrollee's dependent enrolled in the same QHP is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions; or

(iii) A qualified individual or his or her dependent who is enrolled in qualifying coverage in an eligible employer-sponsored plan is determined newly eligible for advance payments of the premium tax credit based in part on a finding that such individual will cease to be eligible for qualifying coverage in an eligible-employer sponsored plan in the next 60 days and is allowed to

terminate existing coverage. The Exchange must permit an individual whose existing coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan, although he or she is not eligible for advance payments of the premium tax credit until the end of his or her coverage through such eligible employer-sponsored plan;

(7) The qualified individual or enrollee, or his or her dependent, gains access to new QHPs as a result of a permanent move;

(8) The qualified individual who is an Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a QHP or change from one QHP to another one time per month; and

(9) The qualified individual or enrollee, or his or her dependent, demonstrates to the Exchange, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances as the Exchange may provide.

(10) The qualified individual or his or her dependent is enrolled in an eligible employer-sponsored plan that is not qualifying coverage in an eligible employer-sponsored plan, as the term is defined in §155.300 of this part, and is allowed to terminate existing coverage. The Exchange must permit such an individual to access this special enrollment period 60 days prior to the end of his or her coverage through such eligible employer-sponsored plan.

164. Section 155.430 is amended by revising paragraphs (b)(1) and (d)(1) to read as follows:

§155.430 Termination of coverage.

* * * * *

(b) * * *

(1) Enrollee-initiated terminations. (i) The Exchange must permit an enrollee to terminate his or her coverage in a QHP, including as a result of the enrollee obtaining other minimum essential coverage, with appropriate notice to the Exchange or the QHP.

(ii) The Exchange must provide an opportunity at the time of plan selection for an enrollee to choose to remain enrolled in a QHP if the Exchange identifies that he or she has become eligible for other minimum essential coverage through the data matching described in §155.330(d) and the enrollee does not request termination in accordance with paragraph (b)(1)(i) of this section. If an enrollee does not choose to remain enrolled in a QHP in such a situation, the Exchange must initiate termination of his or her coverage upon completion of the redetermination process specified in §155.330.

* * * * *

(d) * * *

(1) For purposes of this section-

(i) Reasonable notice is defined as fourteen days from the requested effective date of termination; and

(ii) Changes in eligibility for advance payments of the premium tax credit and cost sharing reductions, including terminations, must adhere to the effective dates specified in §155.330(f).

* * * * *

165. Add Subpart F to read as follows:

Subpart F -- Appeals of Eligibility Determinations for Exchange Participation and Insurance Affordability Programs

Sec.

155.500 Definitions.

155.505 General eligibility appeals requirements.

155.510 Appeals coordination.

155.515 Notice of appeal procedures.

155.520 Appeal requests.

155.525 Eligibility pending appeal.

155.530 Dismissals.

155.535 Informal resolution and hearing requirements.

155.540 Expedited appeals.

155.545 Appeal decisions.

155.550 Appeal record.

155.555 Employer appeals process.

Subpart F -- Appeals of Eligibility Determinations for Exchange Participation and Insurance Affordability Programs

§155.500 Definitions.

In addition to those definitions in §155.20 and §155.300, for purposes of this subpart and §155.740 of subpart H, the following terms have the following meanings:

Appeal record means the appeal decision, all papers and requests filed in the proceeding, and, if a hearing was held, the transcript or recording of hearing testimony or an official report containing the substance of what happened at the hearing, and any exhibits introduced at the hearing.

Appeal request means a clear expression, either orally or in writing, by an applicant, enrollee, employer, or small business employer or employee to have any eligibility determination or redetermination contained in a notice issued in accordance with §155.310(g), §155.330(e)(1)(ii), §155.335(h)(1)(ii), §155.715(e) or (f), or pursuant to future guidance on section 1311(d)(4)(H) of the Affordable Care Act, reviewed by an appeals entity.

Appeals entity means a body designated to hear appeals of eligibility determinations or

redeterminations contained in notices issued in accordance with §§155.310(g), 155.330(e)(1)(ii), 155.335(h)(1)(ii), 155.715(e) and (f), or notices issued in accordance with future guidance on exemptions pursuant to section 1311(d)(4)(H).

Appellant means the applicant or enrollee, the employer, or the small business employer or employee who is requesting an appeal.

De novo review means a review of an appeal without deference to prior decisions in the case.

Evidentiary hearing means a hearing conducted where new evidence may be presented.

Vacate means to set aside a previous action.

§155.505 General eligibility appeals requirements.

(a) General requirements**.** Unless otherwise specified, the provisions of this subpart apply to Exchange eligibility appeals processes, regardless of whether the appeals process is provided by a state-based Exchange appeals entity or by HHS.

(b) Right to appeal. In accordance with §155.355 and future guidance on section 1311(d)(4)(H) of the Affordable Care Act, an applicant or enrollee must have the right to appeal—

(1) An eligibility determination made in accordance with subpart D, including—

(i) An initial determination of eligibility, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions, made in accordance with the standards specified in 45 CFR §155.305(a) through (h); and

(ii) A redetermination of eligibility, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions, made in accordance with 45 CFR §155.330 and §155.335;

(2) An eligibility determination for an exemption made in accordance with future guidance on exemptions pursuant to section 1311(d)(4)(H) of the Affordable Care Act; and

(3) A failure by the Exchange to provide timely notice of an eligibility determination in accordance with §155.310(g), §155.330(e)(1)(ii), or §155.335(h)(1)(ii).

(c) Options for Exchange appeals. Exchange eligibility appeals may be conducted by—

(1) The Exchange, if the Exchange establishes an appeals process in accordance with the requirements of this subpart; or

(2) HHS, upon exhaustion of the state-based Exchange appeals process, or if the Exchange has not established an appeals process in accordance with the requirements of this subpart.

(d) Eligible entities. An appeals process established under this subpart must comply with the requirements of 42 CFR §431.10(c)(2).

(e) Authorized representatives. An appellant may designate an authorized representative to act on his or her behalf, including in making an appeal request, as provided in §155.227.

(f) Accessibility requirements. Appeals processes established under this subpart must comply with the accessibility requirements in §155.205(c).

(g) Judicial review. An appellant may seek judicial review to the extent it is available by law.

§155.510 Appeals coordination.

(a) Agreements. The appeals entity or the Exchange must enter into agreements with the agencies administering insurance affordability programs regarding the appeals processes for such programs as are necessary to fulfill the requirements of this subpart. Such agreements will include a clear delineation of the responsibilities of each entity to support the eligibility appeals process, and must—

(1) Minimize burden on appellants, including not asking the appellant to provide duplicative information or documentation that he or she already provided to an agency administering an insurance affordability program or eligibility appeals process;

(2) Ensure prompt issuance of appeal decisions consistent with timeliness standards established under this subpart; and

(3) Comply with the requirements set forth in 42 CFR 431.10(d).

(b) Coordination for Medicaid and CHIP appeals. (1) Consistent with 42 CFR 431.10(c)(1)(ii) and §457.1120, the appellant must be informed of the option to opt into pursuing his or her appeal of an adverse Medicaid or CHIP determination made by the Exchange directly with the Medicaid or CHIP agency, and if the appellant elects to do so, the appeals entity transmits the eligibility determination and all information provided via secure electronic interface, promptly and without undue delay, to the Medicaid or CHIP agency, as applicable.

(2) Where the Medicaid or CHIP agency has delegated appeals authority to the Exchange appeals entity consistent with 42 CFR 431.10(c)(1)(ii) and the appellant has elected to have the Exchange appeals entity hear the appeal, the appeals entity may include in the appeal decision a determination of Medicaid and CHIP eligibility, provided that—

(i) The appeals entity applies Medicaid and CHIP MAGI-based income standards and standards for citizenship and immigration status, using verification rules and procedures consistent with 42 CFR parts 435 and 457.

(ii) Notices required in connection with an eligibility determination for Medicaid or CHIP are performed by the appeals entity consistent with the standards identified in this subpart, subpart D, and the State Medicaid or CHIP agency consistent with applicable law.

(3) Where the Medicaid or CHIP agency has not delegated appeals authority to the appeals entity and the appellant seeks review of a denial of Medicaid or CHIP eligibility, the appeals entity must transmit the eligibility determination and all information provided as part of the appeal via secure electronic interface, promptly and without undue delay, to the Medicaid or CHIP agency, as applicable.

(4) The Exchange must consider an appellant determined or assessed by the appeals

entity as not potentially eligible for Medicaid or CHIP as ineligible for Medicaid and CHIP based on the applicable Medicaid and CHIP MAGI-based income standards for purposes of determining eligibility for advance payments of the premium tax credit and cost-sharing reductions.

(c) Data exchange. The appeals entity must—

(1) Ensure that all data exchanges that are part of the appeals process, comply with the data exchange requirements in §155.260, §155.270, and §155.345(h); and

(2) Comply with all data sharing requests made by HHS.

§155.515 Notice of appeal procedures.

(a) Requirement to provide notice of appeal procedures. The Exchange must provide notice of appeal procedures at the time that the—

(1) Applicant submits an application; and

(2) Notice of eligibility determination is sent under §155.310(g), §155.330(e)(1)(ii), §155.335(h)(1)(ii), or future guidance on exemptions pursuant to section 1311(d)(4)(H) of the Affordable Care Act.

(b) General content on right to appeal and appeal procedures. Notices described in paragraph (a) of this section must contain—

(1) An explanation of the applicant or enrollee's appeal rights under this subpart;

(2) A description of the procedures by which the applicant or enrollee may request an appeal;

(3) Information on the applicant or enrollee's right to represent himself or herself, or to be represented by legal counsel or an authorized representative;

(4) An explanation of the circumstances under which the appellant's eligibility may be maintained or reinstated pending an appeal decision, as described in §155.525; and

(5) An explanation that an appeal decision for one household member may result in a

change in eligibility for other household members and may be handled as a redetermination in accordance with the standards specified in §155.305.

§155.520 Appeal requests.

(a) General standards for appeal requests. The Exchange and the appeals entity—

(1) Must accept appeal requests submitted—

(i) By telephone;

(ii) By mail;

(iii) In person, if the Exchange or the appeals entity, as applicable, is capable of receiving in-person appeal requests; or

(v) Via the Internet.

(2) May assist the applicant or enrollee in making the appeal request;

(3) Must not limit or interfere with the applicant or enrollee's right to make an appeal request; and

(4) Must consider an appeal request to be valid for the purpose of this subpart, if it is submitted in accordance with the requirements of paragraphs (b) and (c) of this section and §155.505(b).

(b) Appeal request. The Exchange and the appeals entity must allow an applicant or enrollee to request an appeal within 90 days of the date of the notice of eligibility determination.

(c) Appeal of a state-based Exchange appeals entity decision to HHS. If the appellant disagrees with the appeal decision of a state-based Exchange appeals entity, he or she may make an appeal request to HHS within 30 days of the date of the state-based Exchange appeals entity's notice of appeal decision through any of the methods described in paragraph (a)(1) of this section.

(d) Acknowledgement of appeal request. (1) Upon receipt of a valid appeal request pursuant to paragraph (b), (c), or (d)(3)(i) of this section, the appeals entity—

(i) Must send timely acknowledgment to the appellant of the receipt of his or her valid appeal request, including—

(A) Information regarding the appellant's eligibility pending appeal pursuant to §155.525; and

(B) An explanation that any advance payments of the premium tax credit paid on behalf of the tax filer pending appeal are subject to reconciliation under 26 CFR § 1.36B-4.

(ii) Must send timely notice via secure electronic interface of the appeal request and, if applicable, instructions to provide eligibility pending appeal pursuant to §155.525, to the Exchange and to the agencies administering Medicaid or CHIP, where applicable.

(iii) If the appeal request is made pursuant to paragraph (c) of this section, must send timely notice via secure electronic interface of the appeal request to the state-based Exchange appeals entity.

(iv) Must promptly confirm receipt of the records transferred pursuant to paragraph (d)(3) or (4) of this section to the Exchange or the state-based Exchange appeals entity, as applicable.

(2) Upon receipt of an appeal request that is not valid because it fails to meet the requirements of this section or §155.505(b), the appeals entity must—

(i) Promptly and without undue delay, send written notice to the applicant or enrollee that the appeal request has not been accepted and of the nature of the defect in the appeal request; and

(ii) Treat as valid an amended appeal request that meets the requirements of this section and of §155.505(b).

(3) Upon receipt of a valid appeal request pursuant to paragraph (b) of this section, or upon receipt of the notice under paragraph (d)(1)(ii) of this section, the Exchange must transmit via secure electronic interface to the appeals entity—

(i) The appeal request, if the appeal request was initially made to the Exchange; and

(ii) The appellant's eligibility record.

(4) Upon receipt of the notice pursuant to paragraph (d)(1)(iii) of this section, the state-based Exchange appeals entity must transmit via secure electronic interface the appellant's appeal record, including the appellant's eligibility record as received from the Exchange, to HHS.

§155.525 Eligibility pending appeal.

(a) General standards. After receipt of a valid appeal request or notice under §155.520(d)(1)(ii) that concerns an appeal of a redetermination under §155.330(e) or §155.335(h), the Exchange or the Medicaid or CHIP agency, as applicable, must continue to consider the appellant eligible while the appeal is pending in accordance with standards set forth in paragraph (b) of this section or as determined by the Medicaid or CHIP agency consistent with 42 CFR parts 435 and 457, as applicable.

(b) Implementation. The Exchange must continue the appellant's eligibility for enrollment in a QHP, advance payments of the premium tax credit, and cost-sharing reductions, as applicable, in accordance with the level of eligibility immediately before the redetermination being appealed.

§155.530 Dismissals.

(a) Dismissal of appeal. The appeals entity must dismiss an appeal if the appellant,—

(1) Withdraws the appeal request in writing;

(2) Fails to appear at a scheduled hearing;

(3) Fails to submit a valid appeal request as specified in §155.520(a)(4); or

(4) Dies while the appeal is pending.

(b) Notice of dismissal to the appellant. If an appeal is dismissed under paragraph (a) of this section, the appeals entity must provide timely notice to the appellant, including—

(1) The reason for dismissal;

(2) An explanation of the dismissal's effect on the appellant's eligibility; and

(3) An explanation of how the appellant may show good cause why the dismissal should be vacated in accordance with paragraph (d) of this section.

(c) Notice of the dismissal to the Exchange, Medicaid, or CHIP. If an appeal is dismissed under paragraph (a) of this section, the appeals entity must provide timely notice to the Exchange, and to the agency administering Medicaid or CHIP, as applicable, including instruction regarding—

(1) The eligibility determination to implement; and

(2) Discontinuing eligibility provided under §155.525.

(d) Vacating a dismissal. The appeals entity may vacate a dismissal if the appellant makes a written request within 30 days of the date of the notice of dismissal showing good cause why the dismissal should be vacated.

§155.535 Informal resolution and hearing requirements.

(a) Informal resolution. The HHS appeals process will provide an opportunity for informal resolution and a hearing in accordance with the requirements of this section. A state-based Exchange appeals entity may also provide an informal resolution process prior to a hearing, provided that—

(1) The process complies with the scope of review specified in paragraph (e) of this section;

(2) The appellant's right to a hearing is preserved in any case in which the appellant remains dissatisfied with the outcome of the informal resolution process;

(3) If the appeal advances to hearing, the appellant is not asked to provide duplicative information or documentation that he or she previously provided during the application or informal resolution process; and

(4) If the appeal does not advance to hearing, the informal resolution decision is final and binding.

(b) Notice of hearing. When a hearing is scheduled, the appeals entity must send written notice to the appellant of the date, time, and location or format of the hearing no later than 15 days prior to the hearing date.

(c) Conducting the hearing. All hearings under this subpart must be conducted—

(1) At a reasonable date, time, and location or format;

(2) After notice of the hearing, pursuant to paragraph (b) of this section;

(3) As an evidentiary hearing, consistent with paragraph (e) of this section; and

(4) By one or more impartial officials who have not been directly involved in the eligibility determination or any prior Exchange appeal decisions in the same matter.

(d) Procedural rights of an appellant. The appeals entity must provide the appellant with the opportunity to—

(1) Review his or her appeal record, including all documents and records to be used by the appeals entity at the hearing, at a reasonable time before the date of the hearing as well as during the hearing;

(2) Bring witnesses to testify;

(3) Establish all relevant facts and circumstances;

(4) Present an argument without undue interference; and

(5) Question or refute any testimony or evidence, including the opportunity to confront and cross-examine adverse witnesses.

(e) Information and evidence to be considered. The appeals entity must consider the information used to determine the appellant's eligibility as well as any additional relevant evidence presented during the course of the appeal, including at the hearing.

(f) Standard of review. The appeals entity will review the appeal *de novo* and will consider all relevant facts and evidence adduced during the appeal.

§ 155.540 Expedited appeals.

(a) Expedited appeals. The appeals entity must establish and maintain an expedited appeals process for an appellant to request an expedited process where there is an immediate need for health services because a standard appeal could seriously jeopardize the appellant's life or health or ability to attain, maintain, or regain maximum function.

(b) Denial of a request for expedited appeal. If the appeals entity denies a request for an expedited appeal, it must—

(1) Handle the appeal request under the standard process and issue the appeal decision in accordance with §155.545(b)(1); and

(2) Make reasonable efforts to inform the appellant through electronic or oral notification of the denial and, if notified orally, follow up with the appellant by written notice within 2 days of the denial.

§155.545 Appeal decisions.

(a) Appeal decisions. Appeal decisions must—

(1) Be based exclusively on the information and evidence specified in §155.535(e) and the eligibility requirements under subpart D of this part or pursuant to future guidance on section 1311(d)(4)(H) of the Affordable Care Act, as applicable;

(2) State the decision, including a plain language description of the effect of the decision on the appellant's eligibility;

(3) Summarize the facts relevant to the appeal;

(4) Identify the legal basis, including the regulations that support the decision;

(5) State the effective date of the decision; and

(6) If the appeals entity is a state-based Exchange appeals entity, provide an explanation of the appellant's right to pursue the appeal at HHS, if the appellant remains dissatisfied with the eligibility determination.

(b) Notice of appeal decision. The appeals entity—

(1) Must issue written notice of the appeal decision to the appellant within 90 days of the date an appeal request under §155.520(b) or (c) is received, as administratively feasible.

(2) In the case of an appeal request submitted under §155.540 that the appeals entity determines meets the criteria for an expedited appeal, must issue the notice as expeditiously as the appellant's health condition requires, but no later than 3 working days after the appeals entity receives the request for an expedited appeal.

(3) Must provide notice of the appeal decision and instructions to cease pended eligibility to the appellant, if applicable, via secure electronic interface, to the Exchange or the Medicaid or CHIP agency, as applicable.

(c) Implementation of appeal decisions. The Exchange or the Medicaid or CHIP agency, as applicable, upon receiving the notice described in paragraph (b) of this section, must promptly—

(1) Implement the appeal decision retroactive to the date the incorrect eligibility determination was made or at a time determined under §155.330(f), as applicable, or in accordance with the applicable Medicaid or CHIP standards in 42 CFR parts 435 or 457; and

(2) Redetermine the eligibility of household members who have not appealed their own eligibility determinations but whose eligibility may be affected by the appeal decision, in accordance with the standards specified in §155.305.

§ 155.550 Appeal record.

(a) Appellant access to the appeal record. Subject to the requirements of all applicable federal and state laws regarding privacy, confidentiality, disclosure, and personally identifiable information, the appeals entity must make the appeal record accessible to the appellant at a convenient place and time.

(b) Public access to the appeal record. The appeals entity must provide public access to all appeal records, subject to all applicable federal and state laws regarding privacy,

confidentiality, disclosure, and personally identifiable information.

§155.555 Employer appeals process.

(a) General requirements. The provisions of this section apply to employer appeals processes through which an employer may, in response to a notice under §155.310(h), appeal a determination that the employer does not provide minimum essential coverage through an employer-sponsored plan or that the employer does provide that coverage but it is not affordable coverage with respect to an employee.

(b) Exchange employer appeals process. An Exchange may establish an employer appeals process in accordance with the requirements of this section, §155.505(e) through (g), and §155.510(a)(1), (a)(2), and (c). Where an Exchange has not established an employer appeals process, HHS will provide an employer appeals process that meets the requirements of this section, §155.505(e) through (g), and §155.510(a)(1), (a)(2), and (c).

(c) Appeal request. The Exchange and appeals entity, as applicable, must—

(1) Allow an employer to request an appeal within 90 days from the date the notice described under §155.310(h) is sent;

(2) Allow an employer to submit relevant evidence to support the appeal;

(3) Allow an employer to submit an appeal request to—

(i) The Exchange or the Exchange appeals entity, if the Exchange establishes an employer appeals process; or

(ii) HHS, if the Exchange has not established an employer appeals process;

(4) Comply with the requirements of §155.520(a)(1) through (3); and

(5) Consider an appeal request valid if it is submitted in accordance with paragraph (c)(1) of this section and with the purpose of appealing the determination identified in the notice specified in §155.310(h).

(d) Notice of appeal request. Upon receipt of a valid appeal request, the appeals entity

must—

(1) Send timely acknowledgement of the receipt of the appeal request to the employer, including an explanation of the appeals process;

(2) Send timely notice to the employee of the receipt of the appeal request, including—

(i) An explanation of the appeals process;

(ii) Instructions for submitting additional evidence for consideration by the appeals entity; and

(iii) An explanation of the potential effect of the employer's appeal on the employee's eligibility.

(3) Promptly notify the Exchange of the appeal, if the employer did not initially make the appeal request to the Exchange.

(4) Upon receipt of an appeal request that is not valid because it fails to meet the requirements of this section, the appeals entity must—

(i) Promptly and without undue delay, send written notice to the employer that the appeal request has not been accepted and of the nature of the defect in the appeal request; and

(ii) Treat as valid an amended appeal request that meets the requirements of this section, including standards for timeliness.

(e) Transmittal and receipt of records. (1) Upon receipt of a valid appeal request under this section, or upon receipt of the notice under paragraph (d)(3) of this section, the Exchange must promptly transmit via secure electronic interface to the appeal entity—

(i) The appeal request, if the appeal request was initially made to the Exchange; and

(ii) The employee's eligibility record.

(2) The appeals entity must promptly confirm receipt of records transmitted pursuant to paragraph (e)(1) of this section to the entity that transmitted the records.

(f) Dismissal of appeal. The appeals entity—

(1) Must dismiss an appeal under the circumstances specified in §155.530(a)(1) or if the request fails to comply with the standards in paragraph (c)(4) of this section.

(2) Must provide timely notice of the dismissal to the employer, employee, and Exchange including the reason for dismissal; and

(3) May vacate a dismissal if the employer makes a written request within 30 days of the date of the notice of dismissal showing good cause why the dismissal should be vacated.

(g) Procedural rights of the employer. The appeals entity must provide the employer the opportunity to—

(1) Provide relevant evidence for review of the determination of an employee's eligibility for advance payments of the premium tax credit or cost-sharing reductions;

(2) Review—

(i) The information described in §155.310(h)(1);

(ii) Information regarding whether the employee's income is above or below the threshold by which the affordability of employer-sponsored minimum essential coverage is measured, as set forth by standards described in 26 CFR 1.36B; and

(iii) Other data used to make the determination described in §155.305(f) or (g), to the extent allowable by law, except the information described in paragraph (h) of this section.

(h) Confidentiality of employee information. Neither the Exchange nor the appeals entity may make available to an employer any tax return information of an employee as prohibited by §6103 of the Code.

(i) Adjudication of employer appeals. Employer appeals must—

(1) Be reviewed by one or more impartial officials who have not been directly involved in the employee eligibility determination implicated in the appeal;

(2) Consider the information used to determine the employee's eligibility as well as any additional relevant evidence provided by the employer or the employee during the course of the

appeal; and

(3) Be reviewed de novo.

(j) Appeal decisions. Employer appeal decisions must—

(1) Be based exclusively on the information and evidence described in paragraph (i)(2) and the eligibility standards in 45 CFR part 155, subpart D;

(2) State the decision, including a plain language description of the effect of the decision on the employee's eligibility; and

(3) Comply with the requirements set forth in §155.545(a)(3) through (5).

(k) Notice of appeal decision. The appeals entity must provide written notice of the appeal decision within 90 days of the date the appeal request is received, as administratively feasible, to—

(1) The employer. Such notice must include—

(i) The appeal decision; and

(ii) An explanation that the appeal decision does not foreclose any appeal rights the employer may have under subtitle F of the Code.

(2) The employee. Such notice must include the appeal decision.

(3) The Exchange.

(l) Implementation of the appeal decision. After receipt of the notice under paragraph (k)(3) of this section, if the appeal decision affects the employee's eligibility, the Exchange must promptly redetermine the employee's eligibility in accordance with the standards specified in §155.305.

(m) Appeal record. Subject to the requirements of §155.550 and paragraph (h) of this section, the appeal record must be accessible to the employer and to the employee in a convenient format and at a convenient time.

Subpart H – Exchange Functions: Small Business Health Options Program (SHOP)

166. Section 155.705 is amended by adding paragraph (c) to read as follows:

§155.705 Functions of a SHOP.

* * * * *

(c) Coordination with individual market Exchange for eligibility determinations. A SHOP must provide data to the individual market Exchange that corresponds to the service area of the SHOP related to eligibility and enrollment of a qualified employee.

* * * * *

167. Section 155.740 is added to Subpart H to read as follows:

§ 155.740 SHOP employer and employee eligibility appeals requirements.

(a) Definitions. The definitions in §155.20, §155.300, and §155.500 apply to this section.

(b) General requirements. (1) A state, establishing an Exchange pursuant to §155.100, must provide an eligibility appeals process for the SHOP. Where a state has not established an Exchange pursuant to §155.100, HHS will provide an eligibility appeals process for the SHOP that meets the requirements of this section and the requirements in paragraph (b)(2) of this section.

(2) The SHOP appeals entity must conduct appeals in accordance with the requirements established in this section, §155.505(e) through (g), and §155.510(a)(1), (a)(2), and (c).

(c) Employer right to appeal. An employer may appeal—

(1) A notice of denial of eligibility under §155.715(e); or

(2) A failure of the SHOP to make an eligibility determination in a timely manner.

(d) Employee right to appeal. An employee may appeal—

(1) A notice of denial of eligibility under §155.715(f); or

(2) A failure of the SHOP to make an eligibility determination in a timely manner.

(e) Appeals notice requirement. Notices of the right to appeal a denial of eligibility under §155.715(e) or (f) must be written and include—

(1) The reason for the denial of eligibility, including a citation to the applicable regulations; and

(2) The procedure by which the employer or employee may request an appeal of the denial of eligibility.

(f) Appeal request. The SHOP and appeals entity must—

(1) Allow an employer or employee to request an appeal within 90 days from the date of the notice of denial of eligibility to—

(i) The SHOP or the appeals entity; or

(ii) HHS, if no State-based Exchange has been established.

(2) Accept appeal requests submitted through any of the methods described in §155.520(a)(1);

(3) Comply with the requirements of §155.520(a)(2) and (3); and

(4) Consider an appeal request valid if it is submitted in accordance with paragraph (f)(1) of this section.

(g) Notice of appeal request. Upon receipt of a valid appeal request, the appeals entity must—

(1) Send timely acknowledgement to the employer, or employer and employee if an employee is appealing, of the receipt of the appeal request, including—

(i) An explanation of the appeals process; and

(ii) Instructions for submitting additional evidence for consideration by the appeals entity.

(2) Promptly notify the SHOP of the appeal, if the appeal request was not initially made to the SHOP.

(3) Upon receipt of an appeal request that is not valid because it fails to meet the requirements of this section, the appeals entity must—

(i) Promptly and without undue delay, send written notice to the employer or employee that is appealing that the appeal request has not been accepted and of the nature of the defect in the appeal request; and

(ii) Treat as valid an amended appeal request that meets the requirements of this section.

(h) Transmittal and receipt of records. (1) Upon receipt of a valid appeal request under this section, or upon receipt of the notice under paragraph (g)(2) of this section, the SHOP must promptly transmit, via secure electronic interface, to the appeals entity—

(i) The appeal request, if the appeal request was initially made to the SHOP; and

(ii) The eligibility record of the employer or employee that is appealing.

(2) The appeals entity must promptly confirm receipt of records transmitted pursuant to paragraph (h)(1) of this section to the SHOP that transmitted the records.

(i) Dismissal of appeal. The appeals entity—

(1) Must dismiss an appeal if the employer or employee that is appealing—

(i) Withdraws the request in writing; or

(ii) Fails to submit an appeal request meeting the standards specified in paragraph (f)(4) of this section.

(2) Must provide timely notice to the employer or employee that is appealing of the dismissal of the appeal request, including the reason for dismissal, and must notify the SHOP of the dismissal.

(3) May vacate a dismissal if the employer or employee makes a written request within 30 days of the date of the notice of dismissal showing good cause why the dismissal should be vacated.

(j) Procedural rights of the employer or employee. The appeals entity must provide the employer, or the employer and employee if an employee is appealing, the opportunity to submit relevant evidence for review of the eligibility determination.

(k) Adjudication of SHOP appeals. SHOP appeals must—

(1) Comply with the standards set forth in §155.555(i)(1) and (3); and

(2) Consider the information used to determine the employer or employee's eligibility as well as any additional relevant evidence submitted during the course of the appeal by the employer or employee.

(l) Appeal decisions. Appeal decisions must—

(1) Be based solely on—

(i) The evidence referenced in paragraph (k)(2) of this section;

(ii) The eligibility requirements for the SHOP under §155.710(b) or (e), as applicable.

(2) Comply with the standards set forth in §155.545(a)(2) through (5); and

(3) Be effective retroactive to the date the incorrect eligibility determination was made, if the decision finds the employer or employee eligible, or effective as of the date of the notice of the appeal decision, if eligibility is denied.

(m) Notice of appeal decision. The appeals entity must issue written notice of the appeal decision to the employer, or to the employer and employee if an employee is appealing, and to the SHOP within 90 days of the date the appeal request is received.

(n) Implementation of SHOP appeal decisions. The SHOP must promptly implement the appeal decision upon receiving the notice under paragraph (m) of this section.

(o) Appeal record. Subject to the requirements of §155.550, the appeal record must be accessible to the employer, or employer and employee if an employee is appealing, in a convenient format and at a convenient time.

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(Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Program)

Dated: December 6, 2012.

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Marilyn Tavenner,

Acting Administrator,

Centers for Medicare & Medicaid Services.

Approved: December 19, 2012.

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Kathleen Sebelius,

Secretary,

Department of Health and Human Services.

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